

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, January 15, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
PRESENTATION:	Direct Primary Care - Dr. Qamar is Board Certified in Family Medicine and an expert in the fields of Direct Primary Care (DPC), concierge medicine and telemedicine. He is Founder and CEO of MedLion, the nation's largest Direct Primary Care provider, which manages DPC practices in 22 states.	Dr. Samir Qamar, Founder/CEO MedLion

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippets
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, January 15, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Nuxoll, Hagedorn, Tippetts, Lee and Schmidt

ABSENT/ EXCUSED: Senators Smyser (Lodge) and Lacey

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:02 p.m. and welcomed everyone to the first meeting of the Health and Welfare Committee (HWC).

INTRODUCTIONS: **Chairman Heider** introduced the new Senate Page Cameron Floyd, and asked him to tell the HWC about himself. **Cameron Floyd** said he is from Boise and attends Centennial High School. His plans following high school are to serve the mission for his church, obtain his bachelors degree in graphic design, then attend Brigham Young University to get his masters. He enjoys playing sports. He is very thankful to have this opportunity to be a page and gain first hand knowledge about the State government. **Chairman Heider** commented that it is nice to see a young man with goals and welcomed him. **Vice Chairman Martin** commented that he had known Mr. Floyd, his parents, aunt and uncle for many years and he was a very fine young man.

Chairman Heider introduced the HWC Secretary Erin Denker. He excused Senator Lodge due to illness.

PRESENTATION: **Chairman Heider** welcomed and introduced Dr. Samir Qamar who is a direct primary care (DPC) provider, board certified in family medicine and an expert in the fields of DPC, concierge medicine and telemedicine. He is the founder and CEO of MedLion, the nation's largest DPC provider. MedLion managed DPC practices in 22 states.

Dr. Samir Qamar thanked Chairman Heider, the Senators and the audience. He added a special thank you to Senator Thayne for hosting a very nice visit. He explained DPC was new in the field of medicine. He stated the current system of healthcare was failing for two reasons. First, the reliance on a fee-for-service system meant doctors needed to see as many patients as possible per day. Second, insurance was not designed to be used for primary care. **Dr. Qamar** explained his vision for a new model of healthcare based on subscription. He defined insurance as risk management for rare and expensive events. He stated healthcare is the only industry expected to insure both rare and reoccurring events.

Dr. Qamar described DPC as an innovative alternative to conventional health insurance. Preliminary data showed excellent health outcomes for patients enrolled in DPC and a reduction in health care costs. Often, the sum of the membership fees and an augmented insurance plan – called a wraparound plan because it covered care beyond the scope of primary care – was lower than the cost of a comprehensive insurance plan. He continued to discuss several key points in regards to this new concept. (see attachment 1)

DISCUSSION:

Chairman Heider asked what the consensus of doctors was on the demand to decrease the quantity of time they spend on patient visits. **Dr. Qamar** responded many doctors are frustrated, however, the current nature of the business dictates an increased patient load. He stated his company received approximately 10-15 calls per week from doctors in search of an alternative to the traditional medical practice. Doctors are looking for a new way to practice. Employers and patients want affordable, quality solutions.

Senator Hagedorn asked how catastrophic care and when combined with DPC compared with conventional insurance cost. **Dr. Qamar** stated wraparound plans costs were about 25-30% less than traditional insurance and were able to compete on the insurance exchanges.

Vice Chairman Martin asked about how DPC made itself available to the public as well as employers. **Dr. Qamar** stated DPC was originally created to assist low or non-insured individuals. Before the Affordable Care Act was enacted, 55 million people did not have coverage. This was a method to provide affordable coverage. After DPC was included as an option in the Affordable Care Act, employers began to look at DPC as a viable option. Currently, there are pilot programs being done with Medicare and Medicaid. In Colorado and Washington, DPC programs have been setup directly on those state's insurance exchange.

Senator Nuxoll asked if DPC required the same quantity of paperwork as Medicaid. **Dr. Qamar** answered there will always be a need for paperwork in the medical field. He doesn't believe the healthcare field will be completely free of paperwork, but it can be minimized through streamlined practices. He stated the operational model of healthcare will determine the amount of paperwork.

Senator Nuxoll asked if Dr. Qamar would summarize the top concerns of the physicians who attended the prior evening's public meeting. **Dr. Qamar** stated specialists did not understand how primary care had become such a critical facet of medical insurance. He said additional concerns included a greater investment in the foundation of primary care, the upcoming physician shortage and increasing quality of care versus quantity of care.

Senator Hagedorn asked, in Dr. Qamar's opinion, was there a particular demographic that utilized this type of care more than another. Additionally, **Senator Hagedorn** asked what metric was used to measure the success of DPC. **Dr. Qamar** said one particular demographic had not yet stood out. The demand for DPC was spread throughout all demographics.

Dr. Qamar stated the metric for determining DPC's success established by the individual practice's standard of care. His practice's method was based on patient outcome and whether there is a reduction in hospitalizations and extraneous unnecessary referrals. He said the metric was managed through an electronic medical records system making data easy to compile.

Chairman Heider inquired about Dr. Qamar's perception of telemedicine and if it included doctor to doctor communication via web or video conference. **Dr. Qamar** stated he viewed telemedicine as an after hour call to a physician. With newer technology, patients are able to video chat or use an application on their smart phone to communicate with a physician as well as other alternatives. However, none of these options allow a doctor to diagnosis a patient. **Dr. Qamar** stated that he invented a medical device to remotely examine a patient. The vision for telemedicine he is creating allows for patient examinations to occur in any location.

Senator Hagedorn asked how to migrate from traditional, low tech medical practices to nontraditional, electronic based management of the health care system. **Dr. Qamar** stated they have of the tools in place and multiple states as well as Medicare and Medicaid are beginning to manage their healthcare systems in this manner.

Senator Hagedorn wanted to know how the insurance companies' were responding to telemedicine. **Dr. Qamar** stated insurance companies have embraced telemedicine. United Healthcare have a division called "Now Clinic", solely, a telemedicine unit; Blue Cross/Blue Shield and ETNA also have one.

Senator Lee asked if DPC changed the way doctors practiced general medicine. She wanted to know how malpractice fit into the scope of telemedicine. **Dr. Qamar** stated with DPC, doctors practice as they currently do; if they reach their limit of knowledge or expertise, they refer. In the event of a referral, it was preferable to use a wraparound, or catastrophic policy. **Dr. Qamar** said malpractice risk was reduced because of DPC's smaller pool of patients. In response to telemedicine, **Dr. Qamar** stated they have to be smart and triage properly. If the patient needs urgent care, they cannot be seen via video or other forms of telemedicine.

ADJOURNED: There being no further information, **Chairman Heider** adjourned the meeting at 3:52 p.m.

Senator Heider
Chairman

Erin Denker
Committee Secretary

Jenny Smith
Assistant Secretary

BACKGROUND

No. 2939 | AUGUST 6, 2014

Direct Primary Care: An Innovative Alternative to Conventional Health Insurance

Daniel McCorry

Abstract

Insurance-based primary care has grown increasingly complex, inefficient, and restrictive, driving frustrated physicians and patients to seek alternatives. Direct primary care is a rapidly growing form of health care that not only alleviates such frustrations, but also goes above and beyond to offer increased access and improved care at an affordable cost. State and federal policymakers can improve access to direct primary care by removing prohibitive laws and enacting laws that encourage this innovative model to flourish. As restrictions are lifted and awareness expands, direct primary care will likely continue to proliferate as a valuable and viable component of the health care system.

With new concerns over the effects of the Affordable Care Act (ACA)¹ on access to care and continued frustration with third-party reimbursement, innovative care models such as direct primary care may help to provide a satisfying alternative for doctors and patients. Doctors paid directly rather than through the patients' insurance premiums typically provide patients with same-day visits for as long as an hour and offer managed, coordinated, personalized care. Direct primary care—also known as “retainer medicine” or “concierge medicine”²—has grown rapidly in recent years. There are roughly 4,400 direct primary care physicians nationwide,³ up from 756 in 2010 and a mere 146 in 2005.⁴

Direct primary care could resolve many of the underlying problems facing doctors and patients in government and private-sector third-party payment arrangements. It has the potential to provide better health care for patients, create a positive work environment for physicians, and reduce the growing economic burdens on doc-

KEY POINTS

- Direct primary care is financed by direct payment, outside of insurance, usually in the form of a monthly fee. In return, patients have ready access to physicians who deliver continuous, comprehensive, and personalized primary care.
- Direct primary care resolves the growing frustrations with the current health care system, particularly problems with third-party payment, paperwork, and government bureaucracy, experienced both by patients and by their physicians.
- Preliminary data show excellent outcomes for patients enrolled in direct primary care and a reduction in health care costs.
- Policymakers should create a legal and regulatory environment that is less restrictive toward direct primary care.
- If policymakers will encourage change, innovation, and competition instead of just reacting to the increasingly dysfunctional status quo, the possibilities are endless.

This paper, in its entirety, can be found at <http://report.heritage.org/bg2939>

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tors and patients that are caused by the prevailing trends in health policy. With some specific policy changes at the state and federal levels, this innovative approach to primary care services could restore and revolutionize the doctor–patient relationship while improving the quality of care for patients.

In general, direct primary care practices offer greater access and more personalized care to patients in exchange for direct payments from the patient on a monthly or yearly contract. Physicians can evaluate the needs and wants of their unique patient populations and practice medicine accordingly. Patients relying on a direct primary care practice can generally expect “all primary care services covered, including care management and care coordination ... seven-day-a-week, around the clock access to doctors, same-day appointments, office visits of at least 30 minutes, basic tests at no additional charge, and phone and email access to the physician.”⁵ Some practices may offer more services, such as free EKGs and/or medications at wholesale cost.

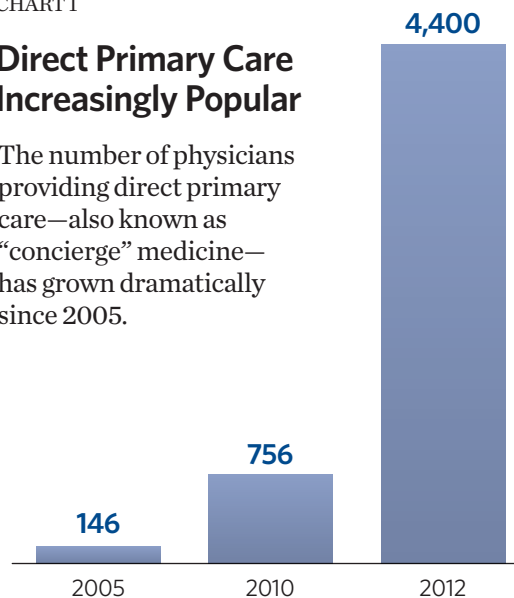
This approach would enable doctors and patients to avoid the bureaucratic complexity, wasteful paperwork and costly claims processing, and growing frustrations with third-party payer systems. It can also cultivate better doctor–patient relationships and reduce the economic burden of health care on patients, doctors, and taxpayers by reducing unnecessary and costly hospital visits.

While the rapid growth in direct primary care is a relatively recent trend, policymakers could help by eliminating barriers to such innovative practices and creating a level playing field for competition. At the state level, policymakers should review and clarify existing laws and regulations, repealing those that impede these arrangements. At the federal level, policymakers should consider facilitating greater

CHART 1

Direct Primary Care Increasingly Popular

The number of physicians providing direct primary care—also known as “concierge” medicine—has grown dramatically since 2005.



Sources: Chris Silva, “Concierge Medicine a Mere Blip on Medicare Radar,” *American Medical News*, September 30, 2010, <http://www.amednews.com/article/20100930/government/309309997/8/> (accessed June 16, 2014), and Elizabeth O’Brien, “Why Concierge Medicine Will Get Bigger,” *The Wall Street Journal MarketWatch*, January 17, 2013, <http://www.marketwatch.com/story/why-concierge-medicine-will-get-bigger-2013-01-17> (accessed July 24, 2014).

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access for patients to direct primary care through the federal tax code and also within existing federal entitlement programs.

The Benefits of Direct Primary Care

While direct primary care is not a new development, it has been given new life because of the growing concerns over the impact of the Affordable Care Act on access to care, such as the doctor shortages,⁶

1. Patient Protection and Affordable Care Act of 2010, Public Law 111-148.

2. These terms have nuanced differences in their meanings but generally refer to similar types of primary care practices. For the purposes of this paper, “direct primary care” will be used.

3. Elizabeth O’Brien, “Why Concierge Medicine Will Get Bigger,” *The Wall Street Journal MarketWatch*, January 17, 2013, <http://www.marketwatch.com/story/why-concierge-medicine-will-get-bigger-2013-01-17> (accessed July 24, 2014).

4. Chris Silva, “Concierge Medicine a Mere Blip on Medicare Radar,” *American Medical News*, September 30, 2010, <http://www.amednews.com/article/20100930/government/309309997/8/> (accessed June 16, 2014).

5. Lisa Zamosky, “Direct-Pay Medical Practices Could Diminish Payer Headaches,” *Medical Economics*, April 24, 2014, <http://medicaleconomics.modernmedicine.com/medical-economics/news/direct-pay-medical-practices-could-diminish-payer-headaches?page=full> (accessed June 3, 2014).

6. Amy Anderson, “The Impact of the Affordable Care Act on the Health Care Workforce,” Heritage Foundation *Background* No. 2887, March 18, 2014, pp. 1–3, <http://www.heritage.org/research/reports/2014/03/the-impact-of-the-affordable-care-act-on-the-health-care-workforce>.

narrow networks,⁷ and frustrations and failures that doctors and patients have experienced with third-party reimbursement.

Before the rapid growth of employer-based health insurance coverage in the 1940s, Americans paid directly with cash for virtually all of their health care. With the rise of third-party health insurance after World War II, cash payment for medical services declined sharply. Doctors, hospitals, and other medical professionals increasingly were reimbursed through third-party insurance, which often provided “first dollar” coverage. Superficially, this seemed to be efficient, quick, and easy, but it had the unintended consequence of making health care financing largely opaque. This hid the true cost of services, leaving patients with the false impression that their employers paid for their medical expenses, except for the occasional co-pay, deductible, or coinsurance.

Over time, the third-party payment systems in both private health insurance and public programs, such as Medicare and Medicaid, have become increasingly complex and costly, less transparent, and more economically inefficient.

This major transition in American health care financing during the 1940s left physicians to seek reimbursement from patients’ insurance companies. Over time, the third-party payment systems in both private health insurance and public programs, such as Medicare and Medicaid, have become increasingly complex and costly, less transparent, and more economically inefficient.

In light of these mounting complexities and inefficiencies, increasingly dissatisfied doctors and patients are looking for innovative ways to deliver and receive primary care. Direct primary care has become a viable solution for many Americans.

Professional Decline. For many physicians, the traditional third-party payer model is becoming increasingly unattractive. A survey by the Physicians Foundation found that most doctors are profoundly dissatisfied and believe that their profession is in decline. Among the “very important” reasons that they give for the decline are too much regulation and paperwork (79.2 percent of physicians); loss of clinical autonomy (64.5 percent); lack of compensation for quality (58.6 percent); and erosion of physician–patient relationship (54.4 percent).⁸

In Medicare and Medicaid, these shortcomings are exacerbated by their outdated payment models, which routinely underpay physicians relative to the private sector while increasing regulatory and reporting requirements as a condition for continued participation. The Affordable Care Act has only increased these regulatory burdens.

For a typical physician, “half of each day can be consumed with clerical and administrative tasks, such as completing insurance claims forms, navigating complex coding requirements, and negotiating with insurance companies over prior approvals and payment rates.”⁹ The Direct Primary Care Coalition estimates that 40 percent of all primary care revenue goes to claims processing and profit for insurance companies.¹⁰ A typical physician would need 7.4 hours per day to provide all of the preventive care as determined by the U.S. Preventive Services Task Force.¹¹ Such time commitment is unfeasible when physicians must spend several hours per day on clerical work. Declining reimbursements have prompted primary care providers to see more patients in an attempt to maintain stable income. This means that

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7. Scott Gottlieb, “The President’s Health Care Law Does Not Equal Health Care Access,” testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, June 12, 2014, <http://www.aei.org/speech/health/scott-gottlieb-the-presidents-health-care-law-does-not-equal-health-care-access/> (accessed July 18, 2014).
 8. The Physicians Foundation, “Practice Arrangements Among Young Physicians, and Their Views Regarding the Future of the U.S. Healthcare System,” 2012, http://www.physiciansfoundation.org/uploads/default/Next_Generation_Physician_Survey.pdf (accessed July 21, 2014).
 9. Robert Pearl, “Malcolm Gladwell: Tell People What It’s Really Like to Be a Doctor,” *Forbes*, March 13, 2014, <http://www.forbes.com/sites/robertpearl/2014/03/13/malcolm-gladwell-tell-people-what-its-really-like-to-be-a-doctor/> (accessed June 4, 2014).
 10. Zamosky, “Direct-Pay Medical Practices Could Diminish Payer Headaches.”
 11. Kimberly S. H. Yarnall et al., “Primary Care: Is There Enough Time for Prevention?” *American Journal of Public Health*, Vol. 93, No. 4 (April 2003), pp. 635–641.
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each visit is only long enough to address the bare essentials, seldom more.

The lack of meaningful interaction and sufficient time for primary care is eroding the doctor–patient relationship. Patients suffer when doctors must see so many of them. Office schedules are almost always full, and doctors are frequently running behind schedule. Patients can expect to wait weeks or even months for an appointment¹² and then often wait an hour or more after they arrive for their appointments to see the doctor. Once the physician sees them, the patient’s chief complaint will be addressed quickly, and the patient will be sent on his or her way.

Patients may feel that they have received poor care, and many do not receive sufficient preventive screening, understand their pharmaceutical regimen, or secure the appropriate management of their chronic diseases. Thomas Bodenheimer, M.D., writing in the *New England Journal of Medicine*, says, “The majority of patients with diabetes, hypertension, and other chronic conditions do not receive adequate clinical care, partly because half of all patients leave their office visits without having understood what the physician said.”¹³

These problems are byproducts of an overloaded third-party payment system that often expects a doctor to care for nearly 3,000 patients, even though he or she is not reimbursed appropriately for doing so. This process undermines sound medical practice and compromises the quality of patient care.

Moreover, while insurers and legislators often support reforms that compensate for quality rather than quantity, such as value-based purchasing in hospitals and pay for performance for physicians, it remains to be seen whether these modest payment reforms will change treatment dynamics.

Benefits of Direct Primary Care. Direct primary care can avoid many of these problems for doctors and patients. Since direct primary care practices

see fewer patients, the physician can spend more time on each visit, offer same-day appointments, and get to know patients well. The doctor no longer feels a need to run from room to room, seeing patients on a tight schedule, just to maintain stable revenues for the practice.

Since direct primary care practices see fewer patients, the physician can spend more time on each visit, offer same-day appointments, and get to know patients well.

Under direct primary care arrangements, revenues are predetermined by the monthly fees, allowing doctors to focus entirely on caring for their patients. In return, patients receive increased access to their physicians, more of their physicians’ attention, and the benefits of more preventive, comprehensive, coordinated care.

Patients with chronic diseases could also benefit from direct primary care. The Centers for Disease Control and Prevention (CDC) recognizes that “Chronic diseases and conditions ... are among the most common, costly, and preventable of all health problems.”¹⁴ Diabetes is a widespread chronic disease and is projected to become more prevalent as the baby-boomer generation ages.¹⁵ Diabetes can also be managed more effectively through better coordinated, longitudinal, preventive primary care such as that provided by direct primary care practices.

The American Diabetes Association estimates that the economic cost of diabetes totaled \$245 billion in 2012 and has found that individuals with uncontrolled diabetes cost “two to eight times more than people with controlled or nonadvanced diabetes.”¹⁶ A study

12. Merritt Hawkins, “Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates,” 2014, pp. 5–6, <http://www.merrithawkins.com/uploadedFiles/MerrittHawkins/Surveys/mha2014waitsurvPDF.pdf> (accessed June 4, 2014).

13. Thomas Bodenheimer, “Primary Care—Will It Survive?” *The New England Journal of Medicine*, Vol. 355, No. 9 (August 31, 2006), pp. 861–864, <http://www.nejm.org/doi/full/10.1056/NEJMp068155> (accessed July 21, 2014).

14. Centers for Disease Control and Prevention, “Chronic Diseases and Health Promotion,” May 9, 2014, <http://www.cdc.gov/chronicdisease/overview/> (accessed June 3, 2014).

15. Dana E. King et al., “The Status of Baby Boomers’ Health in the United States: The Healthiest Generation?” *JAMA Internal Medicine*, Vol. 173, No. 5 (March 11, 2013), pp. 385–386.

16. American Diabetes Association, “Economic Costs of Diabetes in the U.S. in 2012,” *Diabetes Care*, March 6, 2013, p. 9, <http://care.diabetesjournals.org/content/early/2013/03/05/dc12-2625.full.pdf+html> (accessed July 21, 2014).

focusing on specific prevention quality indicators¹⁷ estimated that the costs of two preventive conditions (“uncontrolled diabetes without complications” and “short-term complications”) for diabetes ranged between \$2.3 billion and \$2.8 billion annually. Medicare or Medicaid patients accounted for 49 percent of preventable hospital admissions in this study.¹⁸

While detailed quantitative analysis of the efficacy of direct primary care is scarce, the limited existing research generally supports the value of direct primary care practices. Researchers writing in the *American Journal of Managed Care* evaluated the cost-benefit for MD-Value in Prevention (MDVIP), a collective direct primary care group with practices in 43 states and the District of Columbia. For states in which sufficient patient information was available (New York, Florida, Virginia, Arizona, and Nevada), decreases in preventable hospital use resulted in \$119.4 million in savings in 2010 alone. Almost all of those savings (\$109.2 million) came from Medicare patients.¹⁹ On a per-capita basis, these savings (\$2,551 per patient) were greater than the payment for membership in the medical practices (generally \$1,500–\$1,800 per patient per year).²⁰

The five-state study also showed positive health outcomes for these patients. In 2010 (the most recent year of the study), these patients experienced 56 percent fewer non-elective admissions, 49 percent fewer avoidable admissions, and 63 percent fewer non-avoidable admissions than patients of traditional practices. Additionally, members of MDVIP

“were readmitted 97%, 95%, and 91% less frequently for acute myocardial infarction, congestive heart failure, and pneumonia, respectively.”²¹

A *British Medical Journal* study of Qliance, another direct primary care group practice, also shows positive results. The study found that Qliance’s patients experienced “35% fewer hospitalizations, 65% fewer emergency department visits, 66% fewer specialist visits, and 82% fewer surgeries than similar populations.”²²

Affordable direct primary care is more than just an option for the wealthy. In fact, two-thirds of direct primary care practices charge less than \$135 per month,²³ and these lower-cost practices account for an increasing proportion of the market. For comparison, cable television is projected to cost an average of \$123 per month in 2015.²⁴ Frequently, the sum of the membership fees and an augmented insurance plan—called a “wraparound” plan because it covers costly care beyond the scope of primary care—is *lower* than the cost of a comprehensive insurance plan by itself. If the number of practices continues to increase and compete directly for consumers, prices will likely decline further.

Additionally, under the ACA, individuals enrolled in a direct primary care medical home²⁵ are required only to have insurance that covers what is not covered in the direct primary care program. Section 10104 exempts patients who are enrolled in direct primary care from the individual insurance mandate for primary care services if they have supplementary

17. Prevention quality indicators “are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.” U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, “Prevention Quality Indicators Overview,” http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx (accessed July 21, 2014).
18. Sunny Kim, “Burden of Hospitalizations Primarily Due to Uncontrolled Diabetes,” *Diabetes Care*, Vol. 30, No. 5 (May 2007), pp. 1281-1282, <http://care.diabetesjournals.org/content/30/5/1281.full> (accessed July 22, 2014).
19. Medicare patients comprised approximately 55 percent of the patients.
20. Andrea Klemes et al., “Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization,” *The American Journal of Managed Care*, Vol. 18, No. 12 (December 2012), pp. e453-e460, <http://www.ajmc.com/publications/issue/2012/2012-12-vol18-n12/Personalized-Preventive-Care-Leads-to-Significant-Reductions-in-Hospital-Utilization> (accessed July 22, 2014).
21. *Ibid.*, p. e458.
22. Leigh Page, “The Rise and Further Rise of Concierge Medicine,” *British Medical Journal*, October 28, 2013, p. 2, <http://www.bmj.com/content/347/bmj.f6465> (accessed July 22, 2014).
23. Jen Wiecezner, “Is Obamacare Driving Doctors to Refuse Insurance?” *The Wall Street Journal MarketWatch*, November 12, 2013, <http://www.marketwatch.com/story/is-direct-primary-care-for-you-2013-11-12> (accessed July 31, 2014).
24. News release, “Average Monthly Pay-TV Subscription Bills May Top \$200 by 2020,” NBD Group, April 10, 2012, https://www.npd.com/wps/portal/npd/us/news/press-releases/pr_120410/ (accessed July 8, 2014).
25. Direct primary care practices that qualify as Patient-Centered Medical Homes under the criteria are set forth by the ACA.

qualified coverage for other services. Individuals not enrolled in direct primary care are required under the ACA to have insurance that covers primary care.

Barriers to Direct Primary Care

While the direct primary care sector is growing and attracting a larger patient base, it still remains only a small portion of the health care market and is burdened by a number of obstacles. One major problem is the lack of a policy consensus on direct primary care providers, specifically how the state and federal laws and regulations should treat such practices, if at all. Certain legal issues will continue to deter physicians from pursuing direct primary care until they are addressed.

State Obstacles. The first major issue is whether direct primary care providers are acting as “risk bearing entities” when providing care in exchange for a monthly fee—and should thus be licensed and regulated as insurers.²⁶ Six states (Washington, Maryland, Oregon, West Virginia, Utah, and California) have proposed legislation to address this regulatory issue. The West Virginia legislation established a pilot program for direct pay practices, but it has since expired.²⁷ A California proposal that would allow retainer practices as part of a “multipronged approach” to health care was introduced in 2012, but it died in that state’s Senate Committee on Health.²⁸

Four states have enacted meaningful legislation.²⁹ In March 2012, Utah enacted a law that simply states that primary care practices are exempt from state insurance regulations.³⁰ Other states

have enacted more comprehensive legislation with additional requirements ranging from limitations on the number of patients³¹ to required written disclosures for prospective patients.³²

The lack of clear state policy causes uncertainty and hesitation for physicians looking to form direct primary care practices. Of course, policies and regulations will vary from state to state, but states should create a more predictable regulatory environment for such arrangements. States can enact laws to clarify that direct primary care practices are either explicitly exempt from insurance regulation (as Utah did) or subject only to some simple, limited standards.

Federal Obstacles. At least three federal obstacles hinder the growth of direct primary care practices.

The ACA. The first is how direct primary care practices work, or can work, within the framework of the ACA and the state and federal health care exchanges. In the ACA’s health insurance exchange rules, the U.S. Department of Health and Human Services (HHS) recognized that “direct primary care medical homes are providers, not insurance companies.”³³ While this ruling is substantial, it is far from exhaustive.

That ruling is based on a little-known provision of the ACA that allows the Secretary of Health and Human Services to “permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary.”³⁴ To qualify, direct

26. Sandra J. Carnahan, “Law, Medicine, and Wealth: Does Concierge Medicine Promote Health Care Choice, or Is It a Barrier to Access?” *Stanford Law & Policy Review*, Vol. 17, No. 1 (2006), pp. 132–134.

27. Dave Chase, “Direct Primary Care: 2013 Industry Landscape,” p. 12, <http://scotlandfamilymedicine.com/wp-content/uploads/2014/04/DPC-Overview-Final-long-version-copy.pdf> (accessed July 22, 2014).

28. California S.B. 1320 (2012).

29. Matthew Taber, “Direct Primary Care Regulations,” BHM Healthcare Solutions, August 13, 2013, <http://bhmpc.com/2013/08/direct-primary-care-regulations/> (accessed July 22, 2014).

30. Utah H.B. 240 (2012).

31. Maryland Insurance Administration, “Report on ‘Retainer’ or ‘Boutique’ or ‘Concierge’ Medical Practices and the Business of Insurance,” MIA-2008-12-002, January 2009, [https://www.msba.org/sec_comm/sections/health/docs/homepage/concierge/2009RetainerMedicineReportfinal\(00022566\).pdf](https://www.msba.org/sec_comm/sections/health/docs/homepage/concierge/2009RetainerMedicineReportfinal(00022566).pdf) (accessed July 22, 2014).

32. Oregon S.B. 86, 2011.

33. U.S. Department of Health and Human Services, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans,” *Federal Register*, Vol. 76, No. 136 (July 15, 2011), p. 41900. See also Direct Primary Care Coalition, “Federal Exchange Rules,” 2014, <http://www.dpcare.org/#!/specialties/ctnu> (accessed July 22, 2014), and 45 *Code of Federal Regulations* § 156.245 (July 18, 2014).

34. Patient Protection and Affordable Care Act of 2010, Public Law 111-148, § 10104(a)(3), statute 42 USC § 18021(a)(3).

care medical home enrollment must be coupled with a wraparound insurance plan that “meets all requirements that are otherwise applicable.”³⁵ In essence, the Secretary of Health and Human Services is responsible for setting the criteria that determine which direct primary care plans qualify for the exchanges. However, the secretary has yet to establish the criteria, and HHS has given no indication of when that may happen.

Lack of HHS criteria also hinders insurance companies from creating qualified wraparound plans to put on the exchanges. If insurance companies are uncertain of the criteria for direct care practices, they cannot know which benefits to supply in the wraparound plans.

Currently, only a handful of insurance companies have attempted to embrace direct primary care. Cigna and Michigan Employee Benefits Service (MEBS) have created plans for employers who choose to offer wraparound plans in conjunction with direct primary care.³⁶ Keiser Group is creating plans that work in conjunction with services of MedLion, a direct primary care group.³⁷ Even with the rise of these plans, there is no clear timeline for when they might be available on the health care exchanges.

Health Savings Accounts. The second federal obstacle is the treatment of these arrangements under the provisions of the Internal Revenue Code that deal with health savings accounts (HSAs). The statute says that to be eligible for an HSA, an individual cannot be covered under a high-deductible health plan *and* another health plan “which provides coverage for any benefit which is covered under the high deductible health plan.”³⁸

In theory, this restriction could be addressed by combining a high-deductible health plan with coverage for primary care through a direct primary care

practice. Even so, there would still be another issue. The statute also specifies that funds in an HSA may not be used to purchase insurance.³⁹ Consequently, Congress would still need to amend the statute either to exempt payments for direct primary care from this restriction or to specify that such payments do not constitute payments for insurance coverage. Given that Congress included language in the ACA providing for integration of direct primary care with insurance coverage offered through the exchanges, amending the tax code’s HSA provisions in a similar fashion should not be controversial.

Recognizing these inconsistencies, Senator Maria Cantwell (D-WA), Senator Patty Murray (D-WA), and Representative Jim McDermott (D-WA) wrote a letter to IRS Commissioner John Koskinen asking for clarification of the tax code.⁴⁰

Some Members of Congress have already attempted to address these discrepancies in the federal tax treatment of direct care payments. The Family and Retirement Health Investment Act of 2013 (S. 1031), sponsored by Senator Orrin Hatch (R-UT), would change the language of the Internal Revenue Code to specify that direct primary care is not to be treated as a health plan or insurance and that “periodic fees paid to a primary care physician” count as qualified medical care.⁴¹ This bill has three cosponsors and has been referred to the Senate Committee on Finance. The House companion bill (H.R. 2194), sponsored by Representative Erik Paulson (R-MN), has been referred to the House Subcommittee on Regulatory Reform, Commercial and Antitrust Law.⁴² If this bill became law, Americans would have greater financial incentives to enroll in a direct primary care practice.

It is perfectly reasonable that direct primary care fees should qualify as medical expenses payable through HSAs. The fact that they do not is simply

35. Ibid.

36. Chase, “Direct Primary Care,” pp. 18-19.

37. Wiecezner, “Is Obamacare Driving Doctors to Refuse Insurance?”

38. 26 U.S. Code § 223(c)(1)(A)(ii)(II).

39. 26 U.S. Code § 223(d)(2)(B).

40. Maria Cantwell, Patty Murray, and Jim McDermott, letter to John Koskinen, June 17, 2014, http://media.wix.com/ugd/677d54_4f0975c488f44d4bbef4bf15a4f7f69a.pdf (accessed July 8, 2014).

41. Family and Retirement Health Investment Act of 2013, S. 1031, 113th Cong., 1st Sess., §§ 116 and 203.

42. Family and Retirement Health Investment Act of 2013, H.R. 2194, 113th Cong., 2nd Sess. The bill has six cosponsors: Bill Cassidy (R-LA), Tom Latham (R-IA), Thomas E. Petri (R-WI), John Kline (R-MN), David T. Roe (R-TN), and Bill Posey (R-FL).

an artifact of the inability of the drafters of the HSA statute to anticipate the development of new delivery and payment arrangements such as direct primary care practices.

Medicare Coverage. A third obstacle is the status of payments for direct primary care under Medicare. The central issue is whether or not payment for direct primary care violates Medicare's current balance billing prohibition, which forbids physicians from charging in excess of allowable rates.⁴³

During the George W. Bush Administration, HHS Secretary Tommy G. Thompson responded to congressional inquiries by ruling that physicians are compliant with the law as long as the monthly fees do not contribute toward services already covered by Medicare. Most primary care services are reimbursable under Medicare Part B. Consequently, current Medicare law permits consumer payments to direct primary care providers only for items and services not otherwise covered by the traditional Medicare fee-for-service program.

This restriction makes it very difficult for Medicare patients seeking to engage the services of a Medicare-participating physician directly. The HHS Office of the Inspector General has charged at least one physician with violating the balance billing prohibition.⁴⁴ In 2005, the Government Accountability Office reinforced HHS's official position, saying that direct primary care practices are legal only to the extent that they comply with Centers for Medicare and Medicaid Services (CMS) regulations.⁴⁵

Yet many Medicare patients could benefit from enrolling with direct primary care practices. Medicare patients would likely be more inclined to do so if Congress eliminated current barriers and restrictions on their ability to engage the services of a Medicare-participating physician through a direct primary care arrangement. Under current

law, a Medicare doctor must formally enter into a private contract with the patient under restrictive terms and conditions set by Medicare and drop out of Medicare, refraining from taking all other Medicare patients for two years. This bizarre statutory restriction does not apply to patients' direct payment of physicians in any other government program, including Medicaid.⁴⁶

The empirical evidence indicates that patients with direct primary care experience substantially lower admissions, fewer emergency room visits, and fewer hospitalizations.

In 2011, Representative Bill Cassidy (R-LA) offered legislation (H.R. 3315) to create a pilot program to reimburse direct primary care medical homes under Medicare. The legislation would have allowed payments of up to \$100 per person per month for regular Medicare patients and \$125 for dual-eligible patients (those covered by both Medicare and Medicaid) and outlined the scope of services to be provided for reimbursement eligibility.⁴⁷ The bill died in committee, but Representative Alan Grayson (D-FL) subsequently encouraged the CMS to develop a similar pilot program using its existing authority.⁴⁸

In the case of Medicaid, current law does not preclude states from paying physicians on a retainer or capitated basis for providing beneficiaries with primary care through a direct primary care practice. Direct primary care practices are very close to the "medical home" concept of primary care delivery for beneficiaries with chronic conditions. States could

43. Carnahan, "Law, Medicine, and Wealth," p. 140. This applies only to models of direct primary care that continue to bill insurance for procedures performed, such as MDVIP or Qliance. Several practices, such as AtlasMD, do not bill any insurance whatsoever.

44. *Ibid.*, pp. 143-144.

45. U.S. Government Accountability Office, *Concierge Care Characteristics and Considerations for Medicare*, GAO-05-929, August 2005, <http://www.gao.gov/products/GAO-05-929> (accessed June 15, 2014).

46. Robert E. Moffit, "Congress Should End the Confusion over Medicare Private Contracting," Heritage Foundation *Background* No. 1347, February 18, 2000, <http://www.heritage.org/research/reports/2000/02/congress-shouldend-the-confusion-over-medicare-private-contracting>.

47. Direct M.D. Care Act of 2011, H.R. 3315, 112th Cong., 1st Sess., § 2.

48. Representative Alan Grayson, letter to Richard Gilfillan, February 25, 2013, <http://medicalaccessusa.com/congressman-alan-grayson/> (accessed June 10, 2014).

fund special accounts with debit cards for Medicaid patients, who could use those funds to pay the fees of a direct primary care provider chosen by the beneficiary. As noted, S. 1031 and H.R. 2194 would allow such a Medicaid option.

States pursuing such an approach could potentially reap significant Medicaid savings. The empirical evidence indicates that patients with direct primary care experience substantially lower admissions, fewer emergency room visits, and fewer hospitalizations. If Medicaid patients enjoyed similar experiences, the resulting savings would directly redound to taxpayers. In fact, if the per-capita savings were as substantial as those found in the MDVIP study (\$2,551 per person), the savings to taxpayers could exceed the cost of a state Medicaid account program.⁴⁹

Currently, 40 cents of every dollar of primary care spending goes to insurance company costs rather than to patient benefits.

Related Issues. Some object that direct primary care would create a two-tiered health care system in which those who cannot afford to pay direct care fees would be priced out of access to quality care.⁵⁰ There are several problems with this line of reasoning.

First, it fails to recognize that American health care already is a multitiered system and that the Affordable Care Act is not changing that fact. Indeed, the ACA will likely harden the existing tiers. For example, Medicaid patients already have much more difficulty finding a doctor than those enrolled in private insurance do, and when they find medical care, it is frequently of poorer quality

than the care provided to patients in private coverage or Medicare.⁵¹

Furthermore, a single-tier program, even if it were desirable, would invariably mean that everyone would end up receiving worse, not better, care over time because it would stifle innovation. If innovative clinicians can provide a better option, they should be encouraged, even if it will not immediately be available to all. In a free market, competition will reduce the price of goods and services over time—sometimes rather quickly.

Second, patient cash payments are not necessarily made to physicians in addition to patient payments for an existing comprehensive plan. If a patient opted for a wraparound plan instead of a comprehensive plan, the patient could save money. Currently, 40 cents of every dollar of primary care spending goes to insurance company costs rather than to patient benefits.⁵² Eliminating the spending on insurance for routine medical services, which passes through a complex claims processing system, and instead paying the doctor directly would not only cost less, but also empower the patient.

As Dr. Robert Fields, an award-winning direct primary care physician in Maryland, has stated, “Money is not purified by first passing through an insurance company.”⁵³ As long as the amount of health care spending remains relatively constant or declines, no one is being priced out of health care by direct primary care.

Policymakers in particular should realize that physicians can offer more free care to those who need it most precisely because they have more free time and are spending less time coping with paperwork, claims processing, and the entire set of interactions with health insurance companies that doctors today must endure. Dr. Marcy Zwelling-Aamot, former president of the American Academy of Private Physicians, has noted that “10% of my patients do not pay me one

49. Klemes et al., “Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization.”

50. Sandra J. Carnahan, “Concierge Medicine: Legal and Ethical Issues,” *The Journal of Law, Medicine & Ethics*, Vol. 35, No. 1 (Spring 2007), p. 211, and Michael Stillman, “Concierge Medicine: A ‘Regular’ Physician’s Perspective,” *Annals of Internal Medicine*, Vol. 152, No. 6 (March 16, 2010), pp. 391–392.

51. Kevin D. Dayaratna, “Studies Show: Medicaid Patients Have Worse Access and Outcomes Than the Privately Insured,” Heritage Foundation Backgrounder No. 2740, November 9, 2012, pp. 3–4, <http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured>.

52. Zamosky, “Direct-Pay Medical Practices Could Diminish Payer Headaches.”

53. Robert P. Fields, “Further Perspectives on Concierge Medicine,” *Annals of Internal Medicine*, Vol. 153, No. 4 (August 17, 2010), p. 274.

dime. They receive care in exchange for offering their time at a charitable organization in the community.”⁵⁴

Less time spent dealing with third-party payments, whether in the public or the private sector, opens up new opportunities for charity care. Dr. Robert Fields, for example, reports that he can now “volunteer at a community clinic several times a month,” something for which he did not have time before.⁵⁵ Doctors want to help their patients. Direct primary care is a way to do so affordably and effectively, not a means of cherry-picking wealthy patients.

A survey of over 5,000 physicians by the Doctors Company found that 43 percent of physicians are considering retiring within five years.

Some critics of direct primary care express concern that physicians might abandon their existing patients to start new medical practices. If a physician decides to downsize from 3,000 patients to 600, the situation of the others is a valid concern. The AMA recognized the potential of this problem over a decade ago and established ethical guidelines that require physicians undertaking direct primary care to help former patients find new providers if they do not wish to be part of such a practice.⁵⁶ Verifying compliance with such ethical guidelines is difficult, but one University of Chicago survey of direct care physicians notes that “many physicians reported active involvement in transitioning patients to other

practitioners.... In addition, most retainer practices are in urban areas that are not as affected by physician shortages as more rural settings.”⁵⁷

Another survey suggests that direct primary care can improve access by “salvaging the careers of frustrated physicians and deferring their decision to leave practice.”⁵⁸ For physicians opening direct pay practices straight out of residency or converting from a specialty that does not see patients long term (e.g., emergency room), transferring patients is not even a problem. As long as physicians adhere to the AMA guidelines, there is no ethical concern regarding patient abandonment.

Finally, some argue that the growth in direct primary care will exacerbate the existing national shortage of primary care providers.⁵⁹ In essence, if doctors are seeing fewer patients, the nationwide shortage of access to physicians will increase. Yet direct primary care could have the reverse impact. Many of the physicians converting to direct primary care are so frustrated with existing bureaucratic hassles of government and commercial insurance that they might retire if the direct care option is unavailable.

The retirement problem is very real. A survey of over 5,000 physicians by the Doctors Company found that 43 percent of physicians are considering retiring within five years.⁶⁰ Contributing factors include declining reimbursements, interference by government and insurance companies, and the growing bureaucratic burdens under the Affordable Care Act.

Mark Smith, president of Merritt Hawkins, says that physicians feel “extremely overtaxed, over-run and overburdened.”⁶¹ Of physicians not retiring,

54. Marcy Zwelling-Aamot, “Further Perspectives on Concierge Medicine,” *Annals of Internal Medicine*, Vol. 153, No. 4 (August 17, 2010), pp. 275–276.

55. Fields, “Further Perspectives on Concierge Medicine,” p. 274.

56. Editorial, “Keeping It Ethical: Retainer Practices Have Rules and Restrictions,” *American Medical News*, May 3, 2004, <http://www.amednews.com/article/20040503/opinion/305039986/4/> (accessed June 18, 2014), and Mike Norbut, “Retainer Model Slowly Spreading to Specialties,” *American Medical News*, October 25, 2004, <http://www.amednews.com/article/20041025/business/310259993/6/> (accessed June 5, 2014).

57. G. Caleb Alexander, Jacob Kurlander, and Matthew K. Wynia, “Physicians in Retainer (‘Concierge’) Practice,” *Journal of General Internal Medicine*, Vol. 20, No. 12 (December 2005), p. 1082.

58. Elizabeth Hargrave et al., “Retainer-Based Physicians: Characteristics, Impact, and Policy Consideration,” *MedPAC*, October 2010, http://www.medpac.gov/documents/oct10_retainerbasedphysicians_contractor_cb.pdf (accessed July 15, 2014).

59. Carnahan, “Concierge Medicine,” p. 214.

60. The Doctors Company, “The Future of Health Care: A National Survey of Physicians,” February 29, 2012, p. 21, http://www.thedoctors.com/TDC/Pressroom/CON_ID_004672?refId=FUTURE (accessed June 6, 2014).

61. Kevin B. O’Reilly, “Will a ‘Silent Exodus’ from Medicine Worsen Doctor Shortage?” *American Medical News*, October 8, 2012, <http://www.amednews.com/article/20121008/profession/310089946/1/> (accessed June 4, 2014).

many are seeking research or non-clinical jobs.⁶² For example, dropoutclub.com is a new network devoted entirely to helping physicians procure jobs outside of health care. Smith calls this “a silent exodus.”⁶³ Allowing physicians to practice direct primary care not only addresses the underlying problems facing primary care practice, but also can make primary care appealing once again to more and more physicians, residents, and medical students.

Under the current third-party payment systems, physicians are increasingly overburdened and must see too many patients in too little time. A more important problem is that doctors were never supposed to care for 3,000 patients in the first place. No moral imperative compels physicians to martyr themselves in service to a broken third-party payment system.

Dr. Floyd Russak, a direct primary care internist in Colorado, argues that practicing the current model of “inferior care” is morally wrong when quality care can be provided affordably.⁶⁴ Dr. David Albenberg, a family physician in South Carolina, agrees: “What’s ethical about cutting corners and shortchanging patients in the name of efficiency and productivity?”⁶⁵ Additionally, Russak proposed that physician’s assistants and nurse practitioners could treat younger, healthier individuals, leaving more experienced physicians to care for older, sicker patients. As a result, all patients could receive comprehensive, quality care at a reasonable cost.

What Policymakers Should Do

Direct primary care could resolve many of the underlying problems facing doctors and patients in government and private-sector third-party payment arrangements. It has the potential to provide better health care for patients, create a positive work environment for physicians, and reduce the growing economic burdens on doctors and patients caused by the prevailing trends in health policy, including implementation of the Affordable Care Act of 2010.

The question is not whether direct primary care should be allowed as part of the health system, but how to enable even more direct primary care practices to flourish. In this, policymakers can play a powerful role.

State Policy Recommendations

State legislators who want to see this innovative approach flourish should implement free-market policies so physicians can feel free to start a direct primary care practice without fear of its being outlawed or overregulated out of existence. Specifically, they should:

- **Review, rewrite, or repeal any state law, rule, or regulation that inhibits the growth of direct primary care practices.** For example, Maryland limits services in a given year to an annual physical exam, a follow-up visit, and a number of other visits. Such arbitrary restrictions should be removed.⁶⁶
- **Address insurance regulation and licensure issues.** States that have not done so already should review, and amend as necessary, their laws governing insurance regulation and medical provider licensure so as to ensure that state laws do not create unnecessary impediments to the offering of direct primary care arrangements. In the vast majority of states, physicians remain uncertain about the potential legal complications they could face in operating a direct primary care practice. State lawmakers can easily end that uncertainty, thus enabling physicians to practice with relative confidence and freeing patients from anxiety about the security of their care.

Federal Policy Recommendations

Congress should also make reforms that clarify the status of direct primary care arrangements under the tax code and federal programs. Specifically, Congress should:

62. Drew Lindsay, “Concierge Medicine,” *Washingtonian*, February 1, 2010, <http://www.washingtonian.com/articles/health/concierge-medicine/> (accessed July 22, 2014).

63. O’Reilly, “Will a ‘Silent Exodus’ from Medicine Worsen Doctor Shortage?”

64. Floyd Russak, “Concierge Medicine: A Revolution in Primary Care,” *The Advocate*, October/November 2012, http://www.ademedicalsociety.org/clubportal/images/clubimages/1532/ADEMS_Advocate_OctNov2012.pdf (accessed June 20, 2014).

65. Timothy W. Boden, “Concierge Medicine: Glitz and Glamour or Good Medicine?” *MGMA Connexion*, October 2011, p. 52.

66. Maryland Insurance Administration, “Report on ‘Retainer’ or ‘Boutique’ or ‘Concierge’ Medical Practices.”

- **Reform the federal tax code to allow direct primary care payment for services through health savings accounts.** The tax code treats direct care membership as a form of insurance, inhibiting individuals from opening HSAs if they are also enrolled in a high-deductible insurance plan. Yet HSAs would be an advantageous way for more consumers to pay direct primary care fees, and Congress should amend the tax code to allow them to pay for direct primary care.
- **Establish federal rules allowing medical home services to include direct primary care arrangements.** Current law allows direct primary care practices to be treated as medical home services if the practices meet certain requirements. HHS is responsible for setting these requirements but has not yet done so, effectively inhibiting direct primary care.
- **Change current law and allow Medicare patients to pay doctors directly outside of the traditional Medicare program.** Congress should remove the balanced billing limitations that require physicians to drop out of Medicare for two years if they accept direct payment from Medicare beneficiaries.⁶⁷
- **Encourage states to enable Medicaid patients to pay doctors directly for routine medical services.** Congress should ensure that states have the flexibility to allow for direct payment in Medicaid, perhaps through establishing Medicaid medical accounts.

Creating a Stable Environment for Direct Care to Flourish

Direct primary care could experience explosive growth, driven by increased awareness, better care, clear legislative intent to foster this mode of care, increasing options for non-primary care fields, and

growing discontent among patients and physicians with the current third-party payment system.

Many physicians and patients are discontented, and they will search for other options. Physician discontent is reflected in a recent finding that 90 percent of physicians are unwilling to recommend health care to others as a profession.⁶⁸ Patients are equally disappointed with the current system. A 2014 Merritt Hawkins survey found that the average wait time to see a family physician is 19.5 days.⁶⁹ After that wait, the average patient will actually be seen for only 7.7 minutes.⁷⁰ Discontent on both sides will likely grow, driving doctors and patients to seek alternatives. Direct primary care is one such alternative.

The sheer increase in the number of such practices—nearly 5,500 nationwide—means that more people will likely learn about them from friends, family, and colleagues. As more research about the effectiveness of these practices is published, even more people will learn about them.

Amending federal law could clear the way for further expansion of direct primary care. Given that the ACA already took a small step in that direction, it is possible that such changes could attract bipartisan support in Congress. In particular, legislation to clarify the tax status of direct primary care payment, as well as provisions to allow Medicare and Medicaid patients to enroll in these practices, could accelerate expansion. The rapidly growing Medicare patient population opens up new opportunities for these practices. Because baby boomers will likely have one or more chronic conditions, they would benefit the most from close management under direct primary care.⁷¹

Primary care physicians are the main practitioners in direct care programs. While non-primary care providers are still a small fraction of direct care providers, they do exist, and they have tremendous potential to expand. For example, White Glove Health, a group of nurse practitioners overseen by doctors, is responsible for the care of nearly half a million patients.⁷² Pediatricians, cardiologists, and

67. Moffit, "Congress Should End the Confusion over Medicare Private Contracting."

68. The Doctors Company, "The Future of Health Care," p. 22.

69. Hawkins, "Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates," p. 6.

70. Lauren Block et al., "In the Wake of the 2003 and 2011 Duty Hours Regulations, How Do Internal Medicine Interns Spend Their Time?" *Journal of General Internal Medicine*, Vol. 28, No. 8 (August 2013), pp. 1042-1047.

71. King et al., "The Status of Baby Boomers' Health in the United States."

72. Chase, "Direct Primary Care," p. 6.

other specialists are also branching out into direct care models of practice.⁷³

The possibilities are endless. Instead of paying higher and higher premiums and deductibles, patients could substitute a simple monthly payment. Doctors and other health care professionals could group together under the direct pay format. While insurance premiums could guarantee catastrophic protection, which is what insurance is meant to do,

patients could receive a majority of their care, including specialty care, as part of a monthly fee. If policy-makers will encourage change, innovation, and competition instead of just reacting to the increasingly dysfunctional status quo, the sky is the limit.

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73. Norbut, "Retainer Model Slowly Spreading to Specialties."

BACKGROUND

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Direct Primary Care: An Innovative Alternative to Conventional Health Insurance

Daniel McCorry

Abstract

Insurance-based primary care has grown increasingly complex, inefficient, and restrictive, driving frustrated physicians and patients to seek alternatives. Direct primary care is a rapidly growing form of health care that not only alleviates such frustrations, but also goes above and beyond to offer increased access and improved care at an affordable cost. State and federal policymakers can improve access to direct primary care by removing prohibitive laws and enacting laws that encourage this innovative model to flourish. As restrictions are lifted and awareness expands, direct primary care will likely continue to proliferate as a valuable and viable component of the health care system.

With new concerns over the effects of the Affordable Care Act (ACA)¹ on access to care and continued frustration with third-party reimbursement, innovative care models such as direct primary care may help to provide a satisfying alternative for doctors and patients. Doctors paid directly rather than through the patients' insurance premiums typically provide patients with same-day visits for as long as an hour and offer managed, coordinated, personalized care. Direct primary care—also known as “retainer medicine” or “concierge medicine”²—has grown rapidly in recent years. There are roughly 4,400 direct primary care physicians nationwide,³ up from 756 in 2010 and a mere 146 in 2005.⁴

Direct primary care could resolve many of the underlying problems facing doctors and patients in government and private-sector third-party payment arrangements. It has the potential to provide better health care for patients, create a positive work environment for physicians, and reduce the growing economic burdens on doc-

KEY POINTS

- Direct primary care is financed by direct payment, outside of insurance, usually in the form of a monthly fee. In return, patients have ready access to physicians who deliver continuous, comprehensive, and personalized primary care.
- Direct primary care resolves the growing frustrations with the current health care system, particularly problems with third-party payment, paperwork, and government bureaucracy, experienced both by patients and by their physicians.
- Preliminary data show excellent outcomes for patients enrolled in direct primary care and a reduction in health care costs.
- Policymakers should create a legal and regulatory environment that is less restrictive toward direct primary care.
- If policymakers will encourage change, innovation, and competition instead of just reacting to the increasingly dysfunctional status quo, the possibilities are endless.

This paper, in its entirety, can be found at <http://report.heritage.org/bg2939>

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narrow networks,⁷ and frustrations and failures that doctors and patients have experienced with third-party reimbursement.

Before the rapid growth of employer-based health insurance coverage in the 1940s, Americans paid directly with cash for virtually all of their health care. With the rise of third-party health insurance after World War II, cash payment for medical services declined sharply. Doctors, hospitals, and other medical professionals increasingly were reimbursed through third-party insurance, which often provided “first dollar” coverage. Superficially, this seemed to be efficient, quick, and easy, but it had the unintended consequence of making health care financing largely opaque. This hid the true cost of services, leaving patients with the false impression that their employers paid for their medical expenses, except for the occasional co-pay, deductible, or coinsurance.

Over time, the third-party payment systems in both private health insurance and public programs, such as Medicare and Medicaid, have become increasingly complex and costly, less transparent, and more economically inefficient.

This major transition in American health care financing during the 1940s left physicians to seek reimbursement from patients’ insurance companies. Over time, the third-party payment systems in both private health insurance and public programs, such as Medicare and Medicaid, have become increasingly complex and costly, less transparent, and more economically inefficient.

In light of these mounting complexities and inefficiencies, increasingly dissatisfied doctors and patients are looking for innovative ways to deliver and receive primary care. Direct primary care has become a viable solution for many Americans.

Professional Decline. For many physicians, the traditional third-party payer model is becoming increasingly unattractive. A survey by the Physicians Foundation found that most doctors are profoundly dissatisfied and believe that their profession is in decline. Among the “very important” reasons that they give for the decline are too much regulation and paperwork (79.2 percent of physicians); loss of clinical autonomy (64.5 percent); lack of compensation for quality (58.6 percent); and erosion of physician–patient relationship (54.4 percent).⁸

In Medicare and Medicaid, these shortcomings are exacerbated by their outdated payment models, which routinely underpay physicians relative to the private sector while increasing regulatory and reporting requirements as a condition for continued participation. The Affordable Care Act has only increased these regulatory burdens.

For a typical physician, “half of each day can be consumed with clerical and administrative tasks, such as completing insurance claims forms, navigating complex coding requirements, and negotiating with insurance companies over prior approvals and payment rates.”⁹ The Direct Primary Care Coalition estimates that 40 percent of all primary care revenue goes to claims processing and profit for insurance companies.¹⁰ A typical physician would need 7.4 hours per day to provide all of the preventive care as determined by the U.S. Preventive Services Task Force.¹¹ Such time commitment is unfeasible when physicians must spend several hours per day on clerical work. Declining reimbursements have prompted primary care providers to see more patients in an attempt to maintain stable income. This means that

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7. Scott Gottlieb, “The President’s Health Care Law Does Not Equal Health Care Access,” testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, June 12, 2014, <http://www.aei.org/speech/health/scott-gottlieb-the-presidents-health-care-law-does-not-equal-health-care-access/> (accessed July 18, 2014).
 8. The Physicians Foundation, “Practice Arrangements Among Young Physicians, and Their Views Regarding the Future of the U.S. Healthcare System,” 2012, http://www.physiciansfoundation.org/uploads/default/Next_Generation_Physician_Survey.pdf (accessed July 21, 2014).
 9. Robert Pearl, “Malcolm Gladwell: Tell People What It’s Really Like to Be a Doctor,” *Forbes*, March 13, 2014, <http://www.forbes.com/sites/robertpearl/2014/03/13/malcolm-gladwell-tell-people-what-its-really-like-to-be-a-doctor/> (accessed June 4, 2014).
 10. Zamosky, “Direct-Pay Medical Practices Could Diminish Payer Headaches.”
 11. Kimberly S. H. Yarnall et al., “Primary Care: Is There Enough Time for Prevention?” *American Journal of Public Health*, Vol. 93, No. 4 (April 2003), pp. 635–641.
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focusing on specific prevention quality indicators¹⁷ estimated that the costs of two preventive conditions (“uncontrolled diabetes without complications” and “short-term complications”) for diabetes ranged between \$2.3 billion and \$2.8 billion annually. Medicare or Medicaid patients accounted for 49 percent of preventable hospital admissions in this study.¹⁸

While detailed quantitative analysis of the efficacy of direct primary care is scarce, the limited existing research generally supports the value of direct primary care practices. Researchers writing in the *American Journal of Managed Care* evaluated the cost-benefit for MD-Value in Prevention (MDVIP), a collective direct primary care group with practices in 43 states and the District of Columbia. For states in which sufficient patient information was available (New York, Florida, Virginia, Arizona, and Nevada), decreases in preventable hospital use resulted in \$119.4 million in savings in 2010 alone. Almost all of those savings (\$109.2 million) came from Medicare patients.¹⁹ On a per-capita basis, these savings (\$2,551 per patient) were greater than the payment for membership in the medical practices (generally \$1,500–\$1,800 per patient per year).²⁰

The five-state study also showed positive health outcomes for these patients. In 2010 (the most recent year of the study), these patients experienced 56 percent fewer non-elective admissions, 49 percent fewer avoidable admissions, and 63 percent fewer non-avoidable admissions than patients of traditional practices. Additionally, members of MDVIP

“were readmitted 97%, 95%, and 91% less frequently for acute myocardial infarction, congestive heart failure, and pneumonia, respectively.”²¹

A *British Medical Journal* study of Qliance, another direct primary care group practice, also shows positive results. The study found that Qliance’s patients experienced “35% fewer hospitalizations, 65% fewer emergency department visits, 66% fewer specialist visits, and 82% fewer surgeries than similar populations.”²²

Affordable direct primary care is more than just an option for the wealthy. In fact, two-thirds of direct primary care practices charge less than \$135 per month,²³ and these lower-cost practices account for an increasing proportion of the market. For comparison, cable television is projected to cost an average of \$123 per month in 2015.²⁴ Frequently, the sum of the membership fees and an augmented insurance plan—called a “wraparound” plan because it covers costly care beyond the scope of primary care—is lower than the cost of a comprehensive insurance plan by itself. If the number of practices continues to increase and compete directly for consumers, prices will likely decline further.

Additionally, under the ACA, individuals enrolled in a direct primary care medical home²⁵ are required only to have insurance that covers what is not covered in the direct primary care program. Section 10104 exempts patients who are enrolled in direct primary care from the individual insurance mandate for primary care services if they have supplementary

17. Prevention quality indicators “are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.” U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, “Prevention Quality Indicators Overview,” http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx (accessed July 21, 2014).
18. Sunny Kim, “Burden of Hospitalizations Primarily Due to Uncontrolled Diabetes,” *Diabetes Care*, Vol. 30, No. 5 (May 2007), pp. 1281–1282, <http://care.diabetesjournals.org/content/30/5/1281.full> (accessed July 22, 2014).
19. Medicare patients comprised approximately 55 percent of the patients.
20. Andrea Klemes et al., “Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization,” *The American Journal of Managed Care*, Vol. 18, No. 12 (December 2012), pp. e453–e460, <http://www.ajmc.com/publications/issue/2012/2012-12-vol18-n12/Personalized-Preventive-Care-Leads-to-Significant-Reductions-in-Hospital-Utilization> (accessed July 22, 2014).
21. *Ibid.*, p. e458.
22. Leigh Page, “The Rise and Further Rise of Concierge Medicine,” *British Medical Journal*, October 28, 2013, p. 2, <http://www.bmj.com/content/347/bmj.f6465> (accessed July 22, 2014).
23. Jen Wiczner, “Is Obamacare Driving Doctors to Refuse Insurance?” *The Wall Street Journal MarketWatch*, November 12, 2013, <http://www.marketwatch.com/story/is-direct-primary-care-for-you-2013-11-12> (accessed July 31, 2014).
24. News release, “Average Monthly Pay-TV Subscription Bills May Top \$200 by 2020,” NBD Group, April 10, 2012, https://www.npd.com/wps/portal/npd/us/news/press-releases/pr_120410/ (accessed July 8, 2014).
25. Direct primary care practices that qualify as Patient-Centered Medical Homes under the criteria are set forth by the ACA.

care medical home enrollment must be coupled with a wraparound insurance plan that “meets all requirements that are otherwise applicable.”³⁵ In essence, the Secretary of Health and Human Services is responsible for setting the criteria that determine which direct primary care plans qualify for the exchanges. However, the secretary has yet to establish the criteria, and HHS has given no indication of when that may happen.

Lack of HHS criteria also hinders insurance companies from creating qualified wraparound plans to put on the exchanges. If insurance companies are uncertain of the criteria for direct care practices, they cannot know which benefits to supply in the wraparound plans.

Currently, only a handful of insurance companies have attempted to embrace direct primary care. Cigna and Michigan Employee Benefits Service (MEBS) have created plans for employers who choose to offer wraparound plans in conjunction with direct primary care.³⁶ Keiser Group is creating plans that work in conjunction with services of MedLion, a direct primary care group.³⁷ Even with the rise of these plans, there is no clear timeline for when they might be available on the health care exchanges.

Health Savings Accounts. The second federal obstacle is the treatment of these arrangements under the provisions of the Internal Revenue Code that deal with health savings accounts (HSAs). The statute says that to be eligible for an HSA, an individual cannot be covered under a high-deductible health plan *and* another health plan “which provides coverage for any benefit which is covered under the high deductible health plan.”³⁸

In theory, this restriction could be addressed by combining a high-deductible health plan with coverage for primary care through a direct primary care

practice. Even so, there would still be another issue. The statute also specifies that funds in an HSA may not be used to purchase insurance.³⁹ Consequently, Congress would still need to amend the statute either to exempt payments for direct primary care from this restriction or to specify that such payments do not constitute payments for insurance coverage. Given that Congress included language in the ACA providing for integration of direct primary care with insurance coverage offered through the exchanges, amending the tax code’s HSA provisions in a similar fashion should not be controversial.

Recognizing these inconsistencies, Senator Maria Cantwell (D-WA), Senator Patty Murray (D-WA), and Representative Jim McDermott (D-WA) wrote a letter to IRS Commissioner John Koskinen asking for clarification of the tax code.⁴⁰

Some Members of Congress have already attempted to address these discrepancies in the federal tax treatment of direct care payments. The Family and Retirement Health Investment Act of 2013 (S. 1031), sponsored by Senator Orrin Hatch (R-UT), would change the language of the Internal Revenue Code to specify that direct primary care is not to be treated as a health plan or insurance and that “periodic fees paid to a primary care physician” count as qualified medical care.⁴¹ This bill has three cosponsors and has been referred to the Senate Committee on Finance. The House companion bill (H.R. 2194), sponsored by Representative Erik Paulson (R-MN), has been referred to the House Subcommittee on Regulatory Reform, Commercial and Antitrust Law.⁴² If this bill became law, Americans would have greater financial incentives to enroll in a direct primary care practice.

It is perfectly reasonable that direct primary care fees should qualify as medical expenses payable through HSAs. The fact that they do not is simply

35. Ibid.

36. Chase, “Direct Primary Care,” pp. 18-19.

37. Wiecezner, “Is Obamacare Driving Doctors to Refuse Insurance?”

38. 26 U.S. Code § 223(c)(1)(A)(ii)(II).

39. 26 U.S. Code § 223(d)(2)(B).

40. Maria Cantwell, Patty Murray, and Jim McDermott, letter to John Koskinen, June 17, 2014, http://media.wix.com/ugd/677d54_4f0975c488f44d4bbef4bf15a4f7f69a.pdf (accessed July 8, 2014).

41. Family and Retirement Health Investment Act of 2013, S. 1031, 113th Cong., 1st Sess., §§ 116 and 203.

42. Family and Retirement Health Investment Act of 2013, H.R. 2194, 113th Cong., 2nd Sess. The bill has six cosponsors: Bill Cassidy (R-LA), Tom Latham (R-IA), Thomas E. Petri (R-WI), John Kline (R-MN), David T. Roe (R-TN), and Bill Posey (R-FL).

fund special accounts with debit cards for Medicaid patients, who could use those funds to pay the fees of a direct primary care provider chosen by the beneficiary. As noted, S. 1031 and H.R. 2194 would allow such a Medicaid option.

States pursuing such an approach could potentially reap significant Medicaid savings. The empirical evidence indicates that patients with direct primary care experience substantially lower admissions, fewer emergency room visits, and fewer hospitalizations. If Medicaid patients enjoyed similar experiences, the resulting savings would directly redound to taxpayers. In fact, if the per-capita savings were as substantial as those found in the MDVIP study (\$2,551 per person), the savings to taxpayers could exceed the cost of a state Medicaid account program.⁴⁹

Currently, 40 cents of every dollar of primary care spending goes to insurance company costs rather than to patient benefits.

Related Issues. Some object that direct primary care would create a two-tiered health care system in which those who cannot afford to pay direct care fees would be priced out of access to quality care.⁵⁰ There are several problems with this line of reasoning.

First, it fails to recognize that American health care already is a multitiered system and that the Affordable Care Act is not changing that fact. Indeed, the ACA will likely harden the existing tiers. For example, Medicaid patients already have much more difficulty finding a doctor than those enrolled in private insurance do, and when they find medical care, it is frequently of poorer quality

than the care provided to patients in private coverage or Medicare.⁵¹

Furthermore, a single-tier program, even if it were desirable, would invariably mean that everyone would end up receiving worse, not better, care over time because it would stifle innovation. If innovative clinicians can provide a better option, they should be encouraged, even if it will not immediately be available to all. In a free market, competition will reduce the price of goods and services over time—sometimes rather quickly.

Second, patient cash payments are not necessarily made to physicians in addition to patient payments for an existing comprehensive plan. If a patient opted for a wraparound plan instead of a comprehensive plan, the patient could save money. Currently, 40 cents of every dollar of primary care spending goes to insurance company costs rather than to patient benefits.⁵² Eliminating the spending on insurance for routine medical services, which passes through a complex claims processing system, and instead paying the doctor directly would not only cost less, but also empower the patient.

As Dr. Robert Fields, an award-winning direct primary care physician in Maryland, has stated, “Money is not purified by first passing through an insurance company.”⁵³ As long as the amount of health care spending remains relatively constant or declines, no one is being priced out of health care by direct primary care.

Policymakers in particular should realize that physicians can offer more free care to those who need it most precisely because they have more free time and are spending less time coping with paperwork, claims processing, and the entire set of interactions with health insurance companies that doctors today must endure. Dr. Marcy Zwelling-Aamot, former president of the American Academy of Private Physicians, has noted that “10% of my patients do not pay me one

49. Klemes et al., “Personalized Preventive Care Leads to Significant Reductions in Hospital Utilization.”

50. Sandra J. Carnahan, “Concierge Medicine: Legal and Ethical Issues,” *The Journal of Law, Medicine & Ethics*, Vol. 35, No. 1 (Spring 2007), p. 211, and Michael Stillman, “Concierge Medicine: A ‘Regular’ Physician’s Perspective,” *Annals of Internal Medicine*, Vol. 152, No. 6 (March 16, 2010), pp. 391–392.

51. Kevin D. Dayaratna, “Studies Show: Medicaid Patients Have Worse Access and Outcomes Than the Privately Insured,” Heritage Foundation Backgrounder No. 2740, November 9, 2012, pp. 3–4, <http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured>.

52. Zarnosky, “Direct-Pay Medical Practices Could Diminish Payer Headaches.”

53. Robert P. Fields, “Further Perspectives on Concierge Medicine,” *Annals of Internal Medicine*, Vol. 153, No. 4 (August 17, 2010), p. 274.

many are seeking research or non-clinical jobs.⁶² For example, dropoutclub.com is a new network devoted entirely to helping physicians procure jobs outside of health care. Smith calls this “a silent exodus.”⁶³ Allowing physicians to practice direct primary care not only addresses the underlying problems facing primary care practice, but also can make primary care appealing once again to more and more physicians, residents, and medical students.

Under the current third-party payment systems, physicians are increasingly overburdened and must see too many patients in too little time. A more important problem is that doctors were never supposed to care for 3,000 patients in the first place. No moral imperative compels physicians to martyr themselves in service to a broken third-party payment system.

Dr. Floyd Russak, a direct primary care internist in Colorado, argues that practicing the current model of “inferior care” is morally wrong when quality care can be provided affordably.⁶⁴ Dr. David Albenberg, a family physician in South Carolina, agrees: “What’s ethical about cutting corners and shortchanging patients in the name of efficiency and productivity?”⁶⁵ Additionally, Russak proposed that physician’s assistants and nurse practitioners could treat younger, healthier individuals, leaving more experienced physicians to care for older, sicker patients. As a result, all patients could receive comprehensive, quality care at a reasonable cost.

What Policymakers Should Do

Direct primary care could resolve many of the underlying problems facing doctors and patients in government and private-sector third-party payment arrangements. It has the potential to provide better health care for patients, create a positive work environment for physicians, and reduce the growing economic burdens on doctors and patients caused by the prevailing trends in health policy, including implementation of the Affordable Care Act of 2010.

The question is not whether direct primary care should be allowed as part of the health system, but how to enable even more direct primary care practices to flourish. In this, policymakers can play a powerful role.

State Policy Recommendations

State legislators who want to see this innovative approach flourish should implement free-market policies so physicians can feel free to start a direct primary care practice without fear of its being outlawed or overregulated out of existence. Specifically, they should:

- **Review, rewrite, or repeal any state law, rule, or regulation that inhibits the growth of direct primary care practices.** For example, Maryland limits services in a given year to an annual physical exam, a follow-up visit, and a number of other visits. Such arbitrary restrictions should be removed.⁶⁶
- **Address insurance regulation and licensure issues.** States that have not done so already should review, and amend as necessary, their laws governing insurance regulation and medical provider licensure so as to ensure that state laws do not create unnecessary impediments to the offering of direct primary care arrangements. In the vast majority of states, physicians remain uncertain about the potential legal complications they could face in operating a direct primary care practice. State lawmakers can easily end that uncertainty, thus enabling physicians to practice with relative confidence and freeing patients from anxiety about the security of their care.

Federal Policy Recommendations

Congress should also make reforms that clarify the status of direct primary care arrangements under the tax code and federal programs. Specifically, Congress should:

62. Drew Lindsay, “Concierge Medicine,” *Washingtonian*, February 1, 2010, <http://www.washingtonian.com/articles/health/concierge-medicine/> (accessed July 22, 2014).
63. O’Reilly, “Will a ‘Silent Exodus’ from Medicine Worsen Doctor Shortage?”
64. Floyd Russak, “Concierge Medicine: A Revolution in Primary Care,” *The Advocate*, October/November 2012, http://www.ademedicalsociety.org/clubportal/images/clubimages/1532/ADEMS_Advocate_OctNov2012.pdf (accessed June 20, 2014).
65. Timothy W. Boden, “Concierge Medicine: Glitz and Glamour or Good Medicine?” *MGMA Connexion*, October 2011, p. 52.
66. Maryland Insurance Administration, “Report on ‘Retainer’ or ‘Boutique’ or ‘Concierge’ Medical Practices.”

other specialists are also branching out into direct care models of practice.⁷³

The possibilities are endless. Instead of paying higher and higher premiums and deductibles, patients could substitute a simple monthly payment. Doctors and other health care professionals could group together under the direct pay format. While insurance premiums could guarantee catastrophic protection, which is what insurance is meant to do,

patients could receive a majority of their care, including specialty care, as part of a monthly fee. If policy-makers will encourage change, innovation, and competition instead of just reacting to the increasingly dysfunctional status quo, the sky is the limit.

—*Daniel McCorry is a Graduate Fellow in the Center for Health Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.*

73. Norbut, "Retainer Model Slowly Spreading to Specialties."

AMENDED AGENDA #2
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, January 19, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Presentation	High Five! Mt. Everest Challenge: The Blue Cross of Idaho Foundation has an initiative called High Five, which is dedicated to promoting healthy children through physical activity and healthy foods. As part of the initiative we are launching a challenge for legislators this session, during the challenge, legislators will receive points for being active, eating fruits and vegetables, and drinking water. The kick-off for the challenge will occur on January 21 in the Capitol and the challenge will take place Jan 26 – Feb 27.	Kendra Witt-Doyle, MPH, PhD Blue Cross of Idaho Foundation for Health
Docket No. 16-0210-1401	Idaho Reportable Diseases	Dr. Kathryn Turner
Docket No. 16-0219-1401	Food Safety and Sanitation Standards for Food Establishments	Patrick Guzzle
Docket No. 16-0227-1401	Idaho Radiation Control Rules	Dr. Chris Ball
Docket No. 16-0227-1402	Idaho Radiation Control Rules	Dr. Chris Ball
Docket No. 16-0301-1401	Eligibility for Health Care Assistance for Families and Children	Camille Schiller
Docket No. 16-0305-1401	Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)	Camille Schiller

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, January 19, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Nuxoll, Hagedorn, Tippetts, Lee, Schmidt, and Lacey

ABSENT/ EXCUSED: Senator Lodge

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:01 p.m. and welcomed the audience. He introduced Cameron Floyd as the new Senate Page for the first six weeks of the session.

PRESENTATION: **Kendra Witt-Doyle**, MPH, PhD Blue Cross of Idaho Foundation Manager, gave a presentation entitled "High Five! Mt. Everest Challenge." High Five was originally designed as a statewide effort to fight childhood obesity and was the brain child of Tim Olsen. Blue Cross of Idaho decided to expand its effort to include the 2015 Legislature. The kick-off for the challenge will occur on January 21 at the Capitol, and the challenge will take place January 26 – February 27. The 5 week challenge is designed to "climb" Mt. Everest. The Legislators will be able to undertake this climb by tracking physical activity, eating fruits and vegetables and drinking healthy amounts of water. Daily points will be accrued. There will be 3\$5,000 awards given. The winning Legislators are encouraged to donate their prize money to the elementary school of their choice for physical education equipment. The three top awards will go to the "Fastest Climber", "Sherpa Endurance Climber", and "Healthy Eater." There will also be awards given for reaching milestones; for just accepting to take the challenge, the Legislators will be given a pedometer and a lapel pin. More information can be found on the website at HighFiveldaho.org. (see attachment 1).

Vice Chairman Martin asked who would be participating in the challenge. **Ms. Witt-Doyle** replied that this year only the Legislators would be invited to participate. **Senator Nuxoll** asked how to sign up to participate. **Ms. Witt-Doyle** responded that if Legislators were unable to attend the kick-off on January 21, they could do it by email.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin for rules review.

Vice Chairman Martin read a brief description of administrative rules and gave an explanation of the role Legislators play in making rules. He indicated that it is the job of elected Idaho Legislators to create laws. However, it is impossible to provide for every situation and outline every detail of how those laws will be carried out. This would turn the State Legislature into a year-round body and greatly increase the size of the Idaho Code. Instead, in Idaho the Legislature creates statutory frameworks for programs and policies. The administrative agency then plans out implementation and writes rules to carry out the Legislature's intent. Idaho provides that the State Legislature would then also review annually the rules that state agencies had created. Idaho Legislature has been reviewing agency rules since

1969. He also thanked Erin, the Committee secretary, and Barbara, his secretary for scheduling the rules being covered.

**DOCKET NO.
16-0210-1401:**

Relating to Idaho Reportable Diseases. Dr. Kathryn Turner, Chief of the Bureau of Communicable Disease Prevention, Division of Public Health, said proposed changes to the Idaho Reportable Diseases Chapter would improve consistency and clarity of language throughout the chapter. This is important for health care providers, laboratories, and others that report diseases as well as the Public Health District staff that investigates those diseases. In addition, changes ensure disease control measures are aligned with current public health best practice. The changes being proposed would improve their ability to protect the public's health throughout the State. **Dr. Turner** requested that the Committee adopt **Docket No. 16-0210-1401**. (see attachment 2)

Senator Tippetts indicated that there were some duplications found on pages 23 and 24. **Dr. Turner** agreed that the rule should be on page 24 and would get with the technical department to make that correction.

Senator Tippetts asked about children exhibiting symptoms of a disease in a daycare center. The rule states that they cannot attend until the disease is gone. He asked how available the tests are and how long it will take to get the results. **Dr. Turner** responded that The State of Idaho does the testing and it is a 24-48 hour turnaround time. Two negative specimens indicate that the children are no longer contagious. Parents can take their children to their family physician or to a central district health facility for testing. There is no cost to the parents if they use central district health. In the remote areas of Idaho, testing kits will be driven to the area if they are not available.

Senator Tippetts had questions regarding transferring sexually transmitted diseases. A discussion was held regarding how far back to go when contacting those who may have been affected by the current carrier. There is no specific time period given in the rule. **Dr. Turner** indicated that each instance is different and needs to be handled on a case by case basis. The current rule gives the flexibility to contact as many or as few people as needed. **Senator Tippetts** does not believe that the rule gives the kind of flexibility Dr. Turner sees.

Senator Nuxoll asked what the reasoning was for lowering the level for lead poisoning, and if there were studies indicating the level should be lowered. She was particularly concerned with levels in the Idaho Panhandle area. **Dr. Turner** responded that since 1992 the national standard has been .5. In the Panhandle area it has been .10. In 2013 a survey of 275 children 6 months to 9 years old was taken and approximately 10 children had a level of .5 or above. One child had a .10 level. Lowering the level will make it possible to catch all children who are infected and to educate parents on how to keep them safe.

Senator Nuxoll asked if the children were tested without the parents' consent. **Dr. Turner** indicated that normally lead poisoning is discovered on a regular pediatric or well baby visit. The provider or the lab gets back to the health department when lead poisoning occurs. The health department contacts the doctor and the parents to find the cause and to educate them on lead poisoning. They immediately take steps to find and remove the cause. There is no invasive investigation.

Senator Nuxoll asked what happens to the children when their levels are too high. **Dr. Turner** said it depends on how high. If the level is very high, medication will be given. Steps are taken to remove the problem and a retest is done in about 3 months. Usually by then the level has dropped.

Chairman Heider asked about the reporting time of 1 or 3 days. He also wondered how people determine symptoms. **Dr. Turner** stated that most of the time the reporting dates are based on the impact to the public. Very transmittable diseases need to be caught as soon as possible. Generally, reporting time is based on impact to the public not necessarily the infected person. After symptoms have been diagnosed by a doctor, it is the doctor's responsibility to report the infection to the state agencies. They work together to stop further infection. **Chairman Heider** asked if the Department goes out and finds the people who have come in contact with the infected person. **Dr. Turner** responded that it depends on the disease. The contact group can sometimes be quite large and other times it may only involve immediate family. The scope is very broad and disease detectives are used to help contain the infection.

Senator Schmidt asked if there was a statutory change that prompted the change in the rules. **Dr. Turner** indicated that there was no statutory change. Under the rules the State can determine which diseases need to be reported based on what is happening in Idaho.

Senator Schmidt wondered if there was an additional cost for this increased focus on these types of diseases. **Dr. Turner** responded that the cost is very small because there will only be about 2 reports every 10 years.

Senator Lee said that she has no problem with necrotizing fasciitis being added to the list of diseases. She asked if it was reported before under a different section. **Dr. Turner** said it has been reported before under the term invasive streptococcal infection. The change in reporting is to take out any vagueness so the reporting is more black and white. **Senator Lee** asked if there could be a clarification made on rheumatic fever on the chart on page 34. **Dr. Turner** responded that she will have the technical change made.

MOTION: **Chairman Heider** moved that **Docket No. 16-0210-1401** be approved. **Senator Nuxoll** seconded the motion. The motion carried by voice vote. .

DOCKET NO. 16-0219-1401: **Food Safety and Sanitation Standards for Food Establishments: Patrick Guzzle**, MA, MPH, REHS, Idaho Food Protection Program Manager, Idaho Department of Health and Welfare, stated that he was approached by Jeff Schroeder, Executive Director of Idaho Hunters Feeding the Hungry, and by representatives from the Idaho Food Bank about a rule that would sanction the donation of legally harvested, wild game meat to be donated to the Idaho Food Bank. Currently there are no rules that prohibit or allow said practice. The dilemma was that both parties were willing and open to having such a rule. He worked with Idaho Hunters Feeding the Hungry and the Idaho Food Bank to draft the proposed language for the rule. At a public hearing on October 14, 2014, no opposition to the rule was expressed. Those in attendance were in full support. **Mr. Guzzle** requested that the Committee approve **Docket No. 16-0219-1401**.

Senator Nuxoll stated that she is aware of a problem with donating farm animal meat to the food banks because they must have USDA inspection first, and that isn't possible in many areas. Is there anything that can be done in Idaho to alleviate this problem? **Mr. Patrick** said that beef, poultry, pork, lamb and goats fall under USDA restrictions. Game animals are not in the same classification. Idaho does not have inspection authority. He indicated that if Idaho had any inspection rules in the future, they would have to be at least as stringent as the federal rules.

Senator Hagedorn asked if he had asked the Fish and Game Department to see if they had any problem with it. **Mr. Patrick** indicated that they had helped with the language of the rule.

Senator Schmidt raised a question concerning custom exempt facilities. **Mr. Patrick** explained that those types of facilities are authorized to butcher, but can only return the meat to the original owner. **Senator Schmidt** asked where road-kill applies. **Mr. Patrick** referred back to the term legally harvested and indicated that if the Fish and Game Department deemed the animal legally harvested, it would qualify under the rule. **Senator Lee** questioned the labeling of donated meat and meat that possibly had been in the refrigerator for a number of years and then donated. She asked if one label or two would be required. **Mr. Patrick** responded that one would be enough. The date just signaled to the inspector whether it was used for private use or donated use.

Senator Tippetts asked Mr. Patrick to compare the risk of domestic game versus wild game. **Mr. Patrick** stated that the risk should be relatively low. When customers come to the food bank, they are allowed to choose whether to buy domestic meats or wild game. Information has been provided that if cooking temperatures are over 165 degrees all infections will be eliminated. This is for the protection of both the State and the hunter. (see attachment 3).

MOTION:

Senator Nuxoll moved that **Docket No. 16-0219-1401** be approved. **Senator Schmidt** seconded the motion. The motion carried by voice vote.

**DOCKET NO.
16-0227-1402**

Relating to Idaho Radiation Control Rules: Dr. Christopher Ball, Ph.D., HCLD (HBB), Chief of the Bureau of Laboratories, presented two docket additions. The first is **Docket No. 16-0227-1402**, a chapter rewrite of the Idaho Radiation Control rules, which begins on page 8 of the Pending Fee Rules Review Book. The second, **Docket No. 16-0227-1401** is a repeal of the existing chapter and it is located on pages 58 and 59 of the Pending Rules Review Book. Dr. Ball asked for approval of this docket (see attachment 4).

Senator Tippetts had a question in regard to who pays the fees in relation to the x-ray machines. Is it the owner or the lease holder? **Dr. Ball** indicated that the intent of the rule is for whoever owns and operates the machine to be the person who is required to license it. **Dr. Ball** stated that the person who will be paying the fee is the one who fills out the licenser application on behalf of a facility where the machine is located. **Senator Tippetts** suggested that the rule be rewritten to clarify this definition.

Senator Tippetts questioned the differences in renewal cycles for industrial facilities verses hospitals. **Dr. Ball** said that industrial facilities are usually used for manufacturing. The x-ray machines are completely shielded and greatly reduce the amount of radiation workers are exposed to. The risk of exposure in dental offices is lower than in hospitals. **Senator Tippetts** also requested that the renewal times for fees be more clearly stated in the rule. **Dr. Ball** said he will recommend that the changes be made.

Senator Nuxoll asked if Dr. Ball knew what other kinds of machines were licensed. She also asked what cost is passed on to the consumers. **Dr. Ball** responded that the most common type of licensing was for dental offices and the cost for one machine is \$150 every four years. There are a number of provisions to assist hospitals. One is designed for very large systems such as St. Luke's. A facility will have a radiation control program that monitors the use of these machines. They may choose to pay a \$1,000 fee as long as they send in reports that are developed particularly for the radiation control program. For example, St. Luke's could have a license for the entire facility not each individual clinic. This would result in substantial savings to a very large institution thus minimizing the cost to patients.

Senator Nuxoll asked about the misuse of radiation. **Dr. Ball** said that there are complaints of over exposure but they are very hard to track because the system is paper based. Their department is asking to go to an electronic monitoring system which would make tracking much easier.

Senator Hagedorn expressed concerns about State regulations relating to radiation exposure. He is uncomfortable signing off on something that the Legislature doesn't have control over. There could be a large delta between what they see, and who actually has the documents in their possession. He asked **Dr. Ball** what the procedure would be for his organization to present the necessary information to the Legislature. **Dr. Ball** indicated that they would work out a mutual plan for relaying information. He stated that their agency would certainly monitor changes to make sure that they were appropriate for inclusion or exclusion in the rules. His agency would be open to doing whatever the Legislature asked to make them comfortable with signing off on the rules.

Chairman Heider asked **Dr. Ball's** opinion on licensing radiologists (which Idaho has resisted doing up to this point) versus licensing the machines those same radiologists use. **Dr. Ball** responded that they aren't mandated to personnel operating the machines, only the machines themselves. They are concerned with ensuring that the devices are operating properly to obtain minimal risk to users. **Chairman Heider** asked **Dr. Ball** what his opinion was on whether the State should be moving toward licensing the operator of the x-ray machines. **Dr. Ball** said that speaking for himself, and not the Department of Health and Welfare (Department), there could be advantages to licensing operators; but at what cost? Part of the accreditation process requires operators to meet certain criteria. His major concern is for rural areas where small, but very needed, dental offices can't afford more cost above the cost of the machine itself. There is probably a need for more evaluation concerning this subject.

Senator Schmidt referenced page 14 § 5304, which refers to operator qualifications having an "acceptable amount of training." In the rural areas, who would approve the acceptable amount of training? **Dr. Ball** said the assumption is made that the dentist, through his training, has the appropriate qualifications to provide adequate training and to document the practices he uses for risk management in his own facility. **Senator Schmidt** asked how this would be handled if the machine is leased or if the business was run by a large corporation. **Dr. Ball** indicated that the owner/operator is in charge of the x-ray device and is the one determining what protocols, procedures, and training is in place to meet the requirements. Documentation of the training would be provided when on-site checks are made.

Senator Hagedorn questioned the fiscal note on page 3 relating to the proposed increase in licensure fees to the Department by approximately \$72,000. He asked what the Department receives in fees currently. **Dr. Ball** stated that they receive none. Their funding comes from two sources, the General Fund and a contract with Federal Drug Administration. Such contract is for inspection of mammography devices to ensure that they comply with quality standards of the statutory mandate. By moving to a one time registration fee, it would enable their department to make sure all licensing and records are current.

Senator Hagedorn questioned what percentage of their budget the \$72,100 would equate to. **Dr. Ball** answered by explaining their funding structure in 2014. Total expenditures were \$172,300. Seventy-four percent of that came from the General Fund and \$45,000 came from the contract with the FDA. Expenditures were allocated and 94 percent went to personnel costs, and the operating budget was 6 percent of the \$172,300. They are anticipating that the change of going to this one time registration process is going to increase their operating expenses while personnel expenses will stay very similar. One of the things they have tried to do is

roll out their licensure process in cycles so that they can do an on-site investigation or remote investigation of all of the x-ray devices within the renewal period of that licensure. They are anticipating that the people signing up and paying their fees will see some value to the license fees they are being assessed. This will increase infrastructure costs. They are also looking for a way to continue following up with the pilot project used in dental offices using a remote program done through the mail. A stable funding source will allow support for ongoing costs and the remote evaluation process. This will ensure that all of the x-ray devices are functioning properly.

Senator Schmidt stated that he was impressed with Dr. Ball's testimony and appreciates that his Department is willing to be accountable for this system.

Senator Nuxoll has an issue with licensing a machine and added cost to the customer. She does not approve of the rule.

Senator Hagedorn also has an issue with approving a rule without having knowledge of what is in the documents and not having control over them. He does not approve the rule.

Senator Tippetts asked Dr. Ball what the consequences were of rejection of this rule. **Dr. Ball** stated that if this rule is not approved he would ask that **Docket No. 16-0227-1401** be not approved as well. His biggest concern is that the current system isn't compliant with the statutory mandates.

Senator Tippetts made the comment that he has worked with these types of machines and they require trained persons and documented facilities. He disagrees with Senator Nuxoll's statement of non-approval and understands Senator Hagedorn's point of view regarding control. He expressed that many people don't have the expertise to understand all of the rules and regulations concerning x-ray machines and feels that the Committee has to trust the experts. For that reason, he supports this rule.

MOTION: **Vice Chairman Martin** asked the Secretary to take the roll call vote. **Senators Heider, Martin, Tippetts, Lee, Schmidt** voted aye. **Senators Nuxoll, Hagedorn** voted nay. Roll call is 5 ayes and 2 nay votes. **Docket No. 16-0227-1402** has passed the Committee.

Docket No. 16-0227-1401: **Vice Chairman Martin** asked Dr. Ball to proceed with **Docket No. 16-0227-1401**. **Senator Schmidt** requested for motion.

MOTION: **Vice Chairman Martin** asked for a vote on **Docket No. 16-0227-1401**. **Senator Schmidt** moved to approve **Docket 16-0227-1401**. **Senator Tippetts** seconded the motion. Voice vote carried the motion and **Docket 16-0227-1401** passed the Committee. **Vice Chairman Martin** thanked Dr. Ball for his testimony.

DOCKET NO: 16-0301-1401: **Eligibility for Health Care Assistance for Families and Children: Camille Schiller**, Program Manager for Medicaid Eligibility in the Department of Health and Welfare, Division of Welfare, stated that this docket covers three items that are needed for clarification when determining eligibility for the Medicaid program and to align with federal regulations. The first item revises the definition for parents/caretaker relatives to read "child" instead of "dependent child." The second item describes parents' and caretaker relatives' Medicaid coverage. The word "adult" is being changed to "individual" to allow for parents who may still be minors to receive Medicaid under the parent eligibility group. The final item concerns the eligibility period for individuals determined presumptively eligible by qualified hospitals. **Ms. Schiller** asked to have this rule approved. (see attachment 5).

MOTION: **Chairman Heider** moved for approval of **Docket No. 16-0301-1401.. Senator Schmidt** seconded the motion. Motion passed by the Committee.

DOCKET NO: 16-0305-1401: **Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD): Camille Schiller**, Program Manager for Medicaid Eligibility in the Department of Health and Welfare, Division of Welfare, stated that this docket covers two changes being requested for individuals receiving Nursing Home Assistance or Home and Community Based Services through Medicaid and their financial responsibility referred to as their "Share of Cost." The first request is to add to the list of allowable deductions that can be made to the customer's share of cost calculation. There is no fiscal impact to the General Fund. The second change is in regards to patients who enter the nursing home and seek Medicaid coverage to help pay for these expenses. The annual fiscal impact for this change is a total of \$161,058 of State funding. **Ms. Schiller** asked to have this rule approved. (see attachment 6).

Senator Hagedorn asked about partial month payments. **Ms. Schiller** stated that the way the rule is currently written they would not be responsible for their share during a partial month.

Senator Schmidt indicated that the rule doesn't read well as to whom and when benefits will be paid. **Ms. Schiller** clarified that benefits are only paid to the person living in the home. She indicated that the wording would be changed to accommodate the new rule for cost billing thereby clarifying the statement.

Senator Schmidt asked about clarity on when patients actually begin receiving benefits. **Ms. Schiller** said that to receive benefits patients have to actually be living in the long term care facility, and their shared cost benefits would kick in after they had been there for a number of months. **Senator Schmidt** suggested that the wording state that the benefits are received while they are living in the long term care facility.

Senator Lee asked if there were other benefits patients receive when they live in a long term care facility that are not inclusive of them residing there. **Ms. Schiller** replied that these are basic Medicaid payments that the Department is paying.

VOICE VOTE: **Senator Schmidt** said he would approve this docket with the edit discussed earlier. Motion seconded by **Chairman Heider**. **Docket No. 16-0305-1401** passed by voice vote.

PASSED THE GAVEL: Vice Chairman Martin passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:56 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Assistant Secretary



Senate Health and Welfare Committee

January 19, 2015

Kendra Witt-Doyle, PhD, MPH
Blue Cross Foundation Manager



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- Win cash for elementary schools to purchase activity equipment



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Awards

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 - Fastest Climber: Participant who reaches the Mt. Everest summit first.
 - Sherpa Endurance Climber: Participant who earned the most feet for being physically active.
 - Healthy Eater: Participant who earned the most feet for eating fruits and vegetables and drinking water.



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**Save
the Date**
January 21, 2015
7 - 11 a.m.
Capitol Building
First Floor Rotunda

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7 Jim Olsen's main child.

Website high 5

Docket 16-0210-1401 Talking Points
Dr. Kathryn Turner
Chief, Bureau of Communicable Disease Prevention

Mister Chair, members of the committee, thank you for the opportunity to testify today. My name is Dr. Kathryn Turner. I am Chief of the Bureau of Communicable Disease Prevention within the Division of Public Health. I am here today to present docket number 16-0210-1401, pending rules titled, "Idaho Reportable Diseases." This docket is located behind tab 7 in your binders.

The intent of the changes being proposed to the Idaho Reportable Disease Rules is to provide clarification to language throughout the chapter, ensure disease control measures are consistent with current disease control and prevention practices, and to address specific topics in disease monitoring and control, which I will briefly outline.

First, we want to update chapter language to increase clarification and consistency. To do this, we are proposing small changes in the Definitions sections to clarify Chapter terminology. We are also proposing changes within the disease-specific sections, intended to provide clarification regarding activities that might be undertaken as part of public health investigations. For instance, to align disease control activities with evidence-based practices for enteric diseases like *E. coli* and *Salmonella*, changes proposed improve consistency in how follow-up testing results should be interpreted and when it is safe for a person who has been sick to return to work, school, or daycare without the risk of spreading the disease to others.

Secondly, the pending rule adds one infection to the list of diseases that must be reported to public health agencies in 2015. Echinococcosis is a parasitic disease that is caused by infection with *Echinococcus*, a tiny tapeworm. These tapeworms are one of many disease-causing organisms in our environment that people might come into contact with while enjoying Idaho outdoor activities, like hunting. While it is our understanding that Echinococcosis in Idaho is rare, standardizing the reporting of the infection when it occurs in people will help us better describe the disease and identify risk factors for infection so we can target prevention messages to Idahoans who might be at risk.

Lastly, we are proposing changes to some disease-specific control activities. One change is to reduce the level of lead found in children's blood that must be reported. The current reportable blood lead level in Idaho is 10 micrograms per deciliter of blood in both children and adults. At the time the current level was approved in rule in 1992, there was clear evidence that adverse health effects occurred at those levels. Since then, important new studies have shown a relationship between adverse health effects and lower levels of lead in the blood. The bottom line is that there isn't really any safe level of lead in our bodies; it builds up in soft tissue like our kidneys, liver, and brain and is stored in the bones of our body, including teeth.

Lead is particularly toxic to children's developing nervous systems. At blood levels lower than 10 micrograms per deciliter, children suffer mental and developmental impairments leading to poor outcomes such as poor school performance, a lower IQ, impaired hearing, and reduced growth. As these children grow into adulthood, they are at increased risk for high blood pressure and cardiovascular-related death, decreased kidney function, and a type of tremor affecting the hands.

For these reasons, we are proposing to change the reportable level of blood lead in children to 5 micrograms per deciliter of blood. By doing so, we can identify children who have been exposed to lead earlier than we currently do and work with doctors and parents to determine where the children might have been exposed, and educate parents how to reduce their immediate exposure, and how to prevent future exposures.

We are proposing additional specific changes to three other diseases. These changes consist of clarifying that necrotizing fasciitis is included in the streptococcal disease infections that must be reported to public health, specifying that infections with free-living amoebae, in addition to the specific parasite *Entamoeba histolytica*, should be reported under the reportable condition amebiasis, and simplifying language about work exclusions during infection with Norovirus.

In summary, the proposed changes to the Idaho Reportable Diseases Chapter will improve consistency and clarity of language throughout the chapter. This is important for health care providers, laboratories, and others that report diseases as well as the Public Health District staff that investigate those diseases. In addition, changes ensure disease control measures are aligned with current public health best practice. The changes are being proposed will improve our ability to protect the public's health throughout the state. I ask for the committee's approval of these chapter changes and stand for questions.

Testimony for IDAPA 16.02.19 by Patrick L. Guzikle

- I was approached about one year ago by Jeff Schroeder, Executive Director of Idaho Hunters Feeding the Hungry about a rule that would sanction the donation of legally harvested, wild game meat to the Idaho Foodbank. I was also contacted by representatives from the Idaho Foodbank who indicated that their partner networks of pantries would be interested in a rule that would allow for this kind of donation.
- At the time, there were no rules or policies that prohibited the practice, but neither was there a rule that expressly allowed the practice. This presented a bit of a dilemma as there was an organization wanting to help donate legally harvested game meat (Idaho Hunters Feeding the Hungry) and organizations willing to accept that donation (food pantries) but the rules were, essentially, silent on the issue.
- I researched what other states allow and I worked with Idaho Hunters Feeding the Hungry and the Idaho Foodbank to draft the language that you have in your rule booklet.
- I had a public hearing on October 14. There was no opposition expressed at that meeting and, in fact, the testimony that was received during that meeting was in full support of this proposed rule.

Idaho Department of Health and Welfare – Bureau of Laboratories

[Mr/Madam] Chair, members of the Committee, I'm Dr. Christopher Ball, Chief of the Bureau of Laboratories and it is a pleasure to present two companion dockets for your consideration and adoption this [afternoon/morning]. The first docket is 16-0227-1402, a chapter rewrite of the Idaho Radiation Control rules, which begins on page 8 of your Pending Fee Rules Review Book. The second, docket 16-0227-1401 is a repeal of the existing chapter and it is located on pages 58 and 59 of your Pending Rules Review Book.

Prior to discussing docket 16-0227-1402, I would like to provide you with a very brief summary of the Idaho Radiation Control Program that is housed in the Bureau of Laboratories' Lab Improvement Section. As required by current rule, the Radiation Control program maintains a register of nearly 1600 facilities that utilize x-ray machines in Idaho.

Ninety-three percent (93%) of registered facilities utilize x-ray machines for diagnostic imaging of people and animals. Of those, the greatest proportion (45%) is dental offices, followed by medical, chiropractic, and veterinary practices. Other uses for registered x-ray machines are in industrial and academic settings.

The Radiation Control Program is staffed by two Radiation Physicists who work to ensure that both patients and health care workers are not being overexposed to x-ray radiation. To do this, they perform about 300 onsite facility inspections every year. During these inspections they verify the identity of registered x-ray machines, test the operating parameters of the instrument, evaluate the diagnostic image quality, assess the adequacy of the shielding, and document the safety protocols, qualifications, and training of staff operating x-ray producing devices.

In March of last year, the Program came under new management and special attention was placed on evaluating the current state of the Program to identify opportunities for improvement. Several performance improvement projects were identified. Examples of ongoing projects include: converting paper files into an electronic record keeping system; adjusting staff travel schedules; incorporating new field instrumentation to maximize productivity; assessing the utility of a dental x-ray evaluation by mail process; comparing our current rules and practices with our statutory mandates; and identifying new opportunities for outreach to the regulated community to provide guidance for the safe operation of x-ray devices.

Turning to page 11, the most striking change in the pending fee rule is that 68 pages of technical information from the Council of Radiation Control Program Director's Suggested State Regulations has been incorporated by reference, noting the Idaho specific exclusions where applicable. This incorporation substantially reduces the size and annual publication costs of the rule [78p x \$56 = \$4,368 vs. 10p X \$56 = \$560] while improving its organization, readability and usefulness.

When comparing our current rules and practices with our statutory mandates we discovered inconsistencies that needed to be remedied. As stated previously, our current rules require us to register facilities and x-ray machines. Idaho code requires that *"the board of health and*

Idaho Department of Health and Welfare – Bureau of Laboratories

welfare shall provide, by rule, for general or specific licensing of x-ray producing machines” [I.C. 53-1043]. We brought this discrepancy to the attention of our Deputy Attorney General and he concluded that registration and licensing are not legally synonymous. A license grants permission to do something, whereas, registration is making a list of who is doing it. With this information, it became imperative that we rewrite our rules to comply with our mandate.

If you turn to page 13, Sections 50 through 53, outline the x-ray licensing process, propose licensing fees and renewal periods, and list the application requirements. The transition from a one-time registration process to maintaining an ongoing licensure program will substantially increase the operating costs of the Radiation Control Program. Idaho is one of only a few states that do not charge x-ray licensing fees, and rather than asking for additional state general funds to bolster the Program, we are proposing to charge reasonable fees to offset the new administrative and technical costs associated with licensure. The proposed fees are substantially less than surrounding states and should generate enough receipts to cover the new costs to the program.

Given the scale of change proposed in this pending fee rule, we elected to utilize the negotiated rulemaking process to solicit assistance and comments in re-writing these rules. The Bureau hosted two in-person meetings and two statewide conference calls but had no response. Because we had no involvement in our negotiated rulemaking, we sent letters soliciting feedback and copies of the pending rule to the Idaho Dental, Medical, Veterinary, Chiropractic, and Hospital Boards and Associations, Regional Medical Centers, and Academic Institutions. We have received comments from the Boards of Dentistry, Medicine and Veterinary Medicine and none were opposed to the proposed rules. All three of the Boards expressed some concern about the documentation required to meet the operator qualifications, safety, radiographer training and quarterly audit requirements listed on pages 14-16 in sections 53-04 through 53-06.

It is important to note that these training, safety, and auditing requirements have been in effect since 1998, but were difficult to find within the lengthy and complex information that was republished from the Suggested State Regulations. The comments from these three boards highlight that the rewritten docket has truly improved the clarity of the rules. This also provided the Program with an excellent opportunity to offer technical assistance and outreach to Idaho’s x-ray community. To this end, we have started working with the Board of Veterinary Medicine to develop training and documentation templates that may be appropriate for their membership. In fact, our Laboratory Improvement Manager will be attending the January 26th Board of Veterinary Medicine meeting to discuss these requirements with the board and provide some examples of how the requirements may be met.

I will conclude my formal remarks by thanking you for the opportunity to speak on behalf of the State Lab and respectfully ask that you approve this docket.

At this time, I stand available for questions.

Mr. Chairman and members of the committee, thank you for the opportunity to come before you today.

I am Camille Schiller, Program Manager for Medicaid Eligibility in the Department of Health and Welfare, Division of Welfare.

I will be presenting Docket Number 16-0301-1401 beginning on page 60 of your Health and Welfare Pending Rules Review book.

Pause

This docket covers *three* items that are needed for *clarification* when determining eligibility for the Medicaid program and to *align* with federal regulations.

The *first* item in this docket revises the definition for parents/caretaker relatives to read "child" only, instead of "dependent child".Because other areas of eligibility for Medicaid refer to the determination of who is a "tax dependent",this change will add clarity to this section of the definitions.

The guidance around who is considered an eligible child for parents and caretaker relatives is not altered with the change.

The *second* item in this docket describes parents and caretaker relatives' Medicaid coverage. The word "adult"

is being changed to "individual" to allow for parents who may still be minors to receive Medicaid under the parent eligibility group. This will ensure consistent and adequate coverage for minor parents and children needing Medicaid.

The *final* item in this docket concerns the eligibility period for individuals determined presumptively eligible by qualified hospitals.

The Federal Regulations state that a person who has been determined to be "presumptively eligible" may continue to be eligible through the month AFTER the month of initial application or until a final eligibility decision has been made by the Department.

This change will clarify language and bring these rules into alignment with federal regulations.

No negotiated rulemaking was done, because these rules are aligning with federal regulations and are of a simple nature

I ask you to approve this Pending rule as Final.

This concludes my presentation and I stand for questions.

Mr. Chairman and members of the committee, thank you for the opportunity to come before you today.

I am Camille Schiller, Program Manager for Medicaid Eligibility in the Department of Health and Welfare, Division of Welfare's Self Reliance program.

I will be presenting docket 16-0305-1401 found on page 74 of your Pending Legislative Rules book.

This docket covers two changes that are being requested in the section of the rules regarding patient liability for individuals receiving Nursing Home Assistance or Home and Community Based Services through Medicaid and their financial responsibility towards their cost of care referred to as their "Share of Cost".

The first request is to add to the list of allowable deductions that can be made to the customer's share of cost calculation. This is guidance that is put forth by the Code of Federal Regulations however the rules in this section of IDAPA do not spell out the allowance given for incurred medical expenses that are not covered by Medicaid. It is being requested that this provision be added to the rules while also putting clarification around the types of expenses that are allowed. The term "medically necessary" is also included in this rule and that term is defined in section 16.03.18 Medicaid Cost Sharing.

There is no fiscal impact to the state general fund, or to any other fund, as this rule will align with other sections of IDAPA that already allow these expenses.

The second change that is being requested is in regards to patients who enter the nursing home and seek Medicaid coverage to help pay for these expenses.

The current rule states that those entering a nursing home are assessed a share of cost when they have resided in the nursing home for one full calendar month. For example, if a patient enters the Nursing Home on December 10th they would be charged their "Share of Cost" on January 1st when the facility does their billing. If the patient later leaves the home mid-month in January, the patient's share of cost is not valid since they did not stay the full calendar month. The facility must re-bill with actual costs for the month and issue a refund to the patient for their Share of Cost.

While it would be ideal if all patients entered on the first of the month and stayed for the entire month for bookkeeping purposes, the reality is that many customers enter and exit the nursing home throughout the month. The change of this rule will allow patients to pay for their Share of Cost only AFTER they have resided in a nursing home for one full calendar month. In the example stated before, there would no cause for refunds because the patient was not in the home for the entirety of either of the months of December or January. If the patient continued residence in the nursing home, they would begin paying their Share of Cost on February 1st.

The anticipated annual fiscal impact for this change is a total of \$161,058 (one hundred sixty one thousand, fifty eight dollars) of State funding. This increase will accommodate the portion of the costs for these services while the patient is in care for partial months.... and it will alleviate costly billing processes for providers, and refunding obstacles for patients who do not stay a full calendar month

I ask you to approve this pending rule as Final.

Thank you for your time today, I stand for questions.

Attachment #1
Presentation



Senate Health and Welfare Committee January 19, 2015

Kendra Witt-Doyle, PhD, MPH
Blue Cross Foundation Manager

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- Win cash for elementary schools to purchase activity equipment





www.HighFiveldahoChallenge.org

- Track physical activity, fruit/vegetable, and water consumption
- Earn daily points and “climb” Mt. Everest
 - Example: 1 flight of stairs = 10 feet



Awards

- Three awards of \$5,000 each:
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Kick-off: January 21, 7am – 11am, first floor

Challenge: January 26 – February 27

Awards Luncheon: March 5, first floor

Announce 3 big winners @ event.

- Prizes for reaching milestones
 - Sign up: Pedometer and lapel pin
 - 3,500 feet: Carabineer - *Prize*
 - 7,000 feet: Water bottle - *Prize*
 - 11,335 feet (top): Gym Duffel Bag - *Prize*





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January 21, 2015
7 - 11 a.m.
Capitol Building
First Floor Rotunda

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7

Jim Olsen's main child.

Website High 5

Thank You

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Docket 16-0210-1401 Talking Points
Dr. Kathryn Turner
Chief, Bureau of Communicable Disease Prevention

Mister Chair, members of the committee, thank you for the opportunity to testify today. My name is Dr. Kathryn Turner. I am Chief of the Bureau of Communicable Disease Prevention within the Division of Public Health. I am here today to present docket number 16-0210-1401, pending rules titled, "Idaho Reportable Diseases." This docket is located behind tab 7 in your binders.

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Secondly, the pending rule adds one infection to the list of diseases that must be reported to public health agencies in 2015. Echinococcosis is a parasitic disease that is caused by infection with *Echinococcus*, a tiny tapeworm. These tapeworms are one of many disease-causing organisms in our environment that people might come into contact with while enjoying Idaho outdoor activities, like hunting. While it is our understanding that Echinococcosis in Idaho is rare, standardizing the reporting of the infection when it occurs in people will help us better describe the disease and identify risk factors for infection so we can target prevention messages to Idahoans who might be at risk.

Lastly, we are proposing changes to some disease-specific control activities. One change is to reduce the level of lead found in children's blood that must be reported. The current reportable blood lead level in Idaho is 10 micrograms per deciliter of blood in both children and adults. At the time the current level was approved in rule in 1992, there was clear evidence that adverse health effects occurred at those levels. Since then, important new studies have shown a relationship between adverse health effects and lower levels of lead in the blood. The bottom line is that there isn't really any safe level of lead in our bodies; it builds up in soft tissue like our kidneys, liver, and brain and is stored in the bones of our body, including teeth.

Lead is particularly toxic to children's developing nervous systems. At blood levels lower than 10 micrograms per deciliter, children suffer mental and developmental impairments leading to poor outcomes such as poor school performance, a lower IQ, impaired hearing, and reduced growth. As these children grow into adulthood, they are at increased risk for high blood pressure and cardiovascular-related death, decreased kidney function, and a type of tremor affecting the hands.

For these reasons, we are proposing to change the reportable level of blood lead in children to 5 micrograms per deciliter of blood. By doing so, we can identify children who have been exposed to lead earlier than we currently do and work with doctors and parents to determine where the children might have been exposed, and educate parents how to reduce their immediate exposure, and how to prevent future exposures.

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In summary, the proposed changes to the Idaho Reportable Diseases Chapter will improve consistency and clarity of language throughout the chapter. This is important for health care providers, laboratories, and others that report diseases as well as the Public Health District staff that investigate those diseases. In addition, changes ensure disease control measures are aligned with current public health best practice. The changes are being proposed will improve our ability to protect the public's health throughout the state. I ask for the committee's approval of these chapter changes and stand for questions.

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- At the time, there were no rules or policies that prohibited the practice, but neither was there a rule that expressly allowed the practice. This presented a bit of a dilemma as there was an organization wanting to help donate legally harvested game meat (Idaho Hunters Feeding the Hungry) and organizations willing to accept that donation (food pantries) but the rules were, essentially, silent on the issue.
- I researched what other states allow and I worked with Idaho Hunters Feeding the Hungry and the Idaho Foodbank to draft the language that you have in your rule booklet.
- I had a public hearing on October 14. There was no opposition expressed at that meeting and, in fact, the testimony that was received during that meeting was in full support of this proposed rule.

Attachment
16-0227-1401
16-0227-1402 #4

Idaho Department of Health and Welfare – Bureau of Laboratories

[Mr/Madam] Chair, members of the Committee, I'm Dr. Christopher Ball, Chief of the Bureau of Laboratories and it is a pleasure to present two companion dockets for your consideration and adoption this [afternoon/morning]. The first docket is 16-0227-1402, a chapter rewrite of the Idaho Radiation Control rules, which begins on page 8 of your Pending Fee Rules Review Book. The second, docket 16-0227-1401 is a repeal of the existing chapter and it is located on pages 58 and 59 of your Pending Rules Review Book.

Prior to discussing docket 16-0227-1402, I would like to provide you with a very brief summary of the Idaho Radiation Control Program that is housed in the Bureau of Laboratories' Lab Improvement Section. As required by current rule, the Radiation Control program maintains a register of nearly 1600 facilities that utilize x-ray machines in Idaho.

Ninety-three percent (93%) of registered facilities utilize x-ray machines for diagnostic imaging of people and animals. Of those, the greatest proportion (45%) is dental offices, followed by medical, chiropractic, and veterinary practices. Other uses for registered x-ray machines are in industrial and academic settings.

The Radiation Control Program is staffed by two Radiation Physicists who work to ensure that both patients and health care workers are not being overexposed to x-ray radiation. To do this, they perform about 300 onsite facility inspections every year. During these inspections they verify the identity of registered x-ray machines, test the operating parameters of the instrument, evaluate the diagnostic image quality, assess the adequacy of the shielding, and document the safety protocols, qualifications, and training of staff operating x-ray producing devices.

In March of last year, the Program came under new management and special attention was placed on evaluating the current state of the Program to identify opportunities for improvement. Several performance improvement projects were identified. Examples of ongoing projects include: converting paper files into an electronic record keeping system; adjusting staff travel schedules; incorporating new field instrumentation to maximize productivity; assessing the utility of a dental x-ray evaluation by mail process; comparing our current rules and practices with our statutory mandates; and identifying new opportunities for outreach to the regulated community to provide guidance for the safe operation of x-ray devices.

Turning to page 11, the most striking change in the pending fee rule is that 68 pages of technical information from the Council of Radiation Control Program Director's Suggested State Regulations has been incorporated by reference, noting the Idaho specific exclusions where applicable. This incorporation substantially reduces the size and annual publication costs of the rule [78p x \$56 = \$4,368 vs. 10p X \$56 = \$560] while improving its organization, readability and usefulness.

When comparing our current rules and practices with our statutory mandates we discovered inconsistencies that needed to be remedied. As stated previously, our current rules require us to register facilities and x-ray machines. Idaho code requires that *"the board of health and*

Idaho Department of Health and Welfare – Bureau of Laboratories

welfare *shall provide, by rule, for general or specific licensing of x-ray producing machines*" [I.C. 53-1043]. We brought this discrepancy to the attention of our Deputy Attorney General and he concluded that registration and licensing are not legally synonymous. A license grants permission to do something, whereas, registration is making a list of who is doing it. With this information, it became imperative that we rewrite our rules to comply with our mandate.

If you turn to page 13, Sections 50 through 53, outline the x-ray licensing process, propose licensing fees and renewal periods, and list the application requirements. The transition from a one-time registration process to maintaining an ongoing licensure program will substantially increase the operating costs of the Radiation Control Program. Idaho is one of only a few states that do not charge x-ray licensing fees, and rather than asking for additional state general funds to bolster the Program, we are proposing to charge reasonable fees to offset the new administrative and technical costs associated with licensure. The proposed fees are substantially less than surrounding states and should generate enough receipts to cover the new costs to the program.

Given the scale of change proposed in this pending fee rule, we elected to utilize the negotiated rulemaking process to solicit assistance and comments in re-writing these rules. The Bureau hosted two in-person meetings and two statewide conference calls but had no response. Because we had no involvement in our negotiated rulemaking, we sent letters soliciting feedback and copies of the pending rule to the Idaho Dental, Medical, Veterinary, Chiropractic, and Hospital Boards and Associations, Regional Medical Centers, and Academic Institutions. We have received comments from the Boards of Dentistry, Medicine and Veterinary Medicine and none were opposed to the proposed rules. All three of the Boards expressed some concern about the documentation required to meet the operator qualifications, safety, radiographer training and quarterly audit requirements listed on pages 14-16 in sections 53-04 through 53-06.

It is important to note that these training, safety, and auditing requirements have been in effect since 1998, but were difficult to find within the lengthy and complex information that was republished from the Suggested State Regulations. The comments from these three boards highlight that the rewritten docket has truly improved the clarity of the rules. This also provided the Program with an excellent opportunity to offer technical assistance and outreach to Idaho's x-ray community. To this end, we have started working with the Board of Veterinary Medicine to develop training and documentation templates that may be appropriate for their membership. In fact, our Laboratory Improvement Manager will be attending the January 26th Board of Veterinary Medicine meeting to discuss these requirements with the board and provide some examples of how the requirements may be met.

I will conclude my formal remarks by thanking you for the opportunity to speak on behalf of the State Lab and respectfully ask that you approve this docket.

At this time, I stand available for questions.

Mr. Chairman and members of the committee, thank you for the opportunity to come before you today.

I am Camille Schiller, Program Manager for Medicaid Eligibility in the Department of Health and Welfare, Division of Welfare.

I will be presenting Docket Number 16-0301-1401 beginning on page 60 of your Health and Welfare Pending Rules Review book.

Pause

This docket covers *three* items that are needed for *clarification* when determining eligibility for the Medicaid program and to *align* with federal regulations.

The *first* item in this docket revises the definition for parents/caretaker relatives to read "child" only, instead of "dependent child".Because other areas of eligibility for Medicaid refer to the determination of who is a "tax dependent",this change will add clarity to this section of the definitions.

The guidance around who is considered an eligible child for parents and caretaker relatives is not altered with the change.

The *second* item in this docket describes parents and caretaker relatives' Medicaid coverage. The word "adult"

is being changed to "individual" to allow for parents who may still be minors to receive Medicaid under the parent eligibility group. This will ensure consistent and adequate coverage for minor parents and children needing Medicaid.

The *final* item in this docket concerns the eligibility period for individuals determined presumptively eligible by qualified hospitals.

The Federal Regulations state that a person who has been determined to be "presumptively eligible" may continue to be eligible through the month AFTER the month of initial application or until a final eligibility decision has been made by the Department.

This change will clarify language and bring these rules into alignment with federal regulations.

No negotiated rulemaking was done, because these rules are aligning with federal regulations and are of a simple nature

I ask you to approve this Pending rule as Final.

This concludes my presentation and I stand for questions.

Mr. Chairman and members of the committee, thank you for the opportunity to come before you today.

I am Camille Schiller, Program Manager for Medicaid Eligibility in the Department of Health and Welfare, Division of Welfare's Self Reliance program.

I will be presenting docket 16-0305-1401 found on page 74 of your Pending Legislative Rules book.

This docket covers two changes that are being requested in the section of the rules regarding patient liability for individuals receiving Nursing Home Assistance or Home and Community Based Services through Medicaid and their financial responsibility towards their cost of care referred to as their "Share of Cost".

The first request is to add to the list of allowable deductions that can be made to the customer's share of cost calculation. This is guidance that is put forth by the Code of Federal Regulations however the rules in this section of IDAPA do not spell out the allowance given for incurred medical expenses that are not covered by Medicaid. It is being requested that this provision be added to the rules while also putting clarification around the types of expenses that are allowed. The term "medically necessary" is also included in this rule and that term is defined in section 16.03.18 Medicaid Cost Sharing.

There is no fiscal impact to the state general fund, or to any other fund, as this rule will align with other sections of IDAPA that already allow these expenses.

The second change that is being requested is in regards to patients who enter the nursing home and seek Medicaid coverage to help pay for these expenses.

The current rule states that those entering a nursing home are assessed a share of cost when they have resided in the nursing home for one full calendar month. For example, if a patient enters the Nursing Home on December 10th they would be charged their "Share of Cost" on January 1st when the facility does their billing. If the patient later leaves the home mid-month in January, the patient's share of cost is not valid since they did not stay the full calendar month. The facility must re-bill with actual costs for the month and issue a refund to the patient for their Share of Cost.

While it would be ideal if all patients entered on the first of the month and stayed for the entire month for bookkeeping purposes, the reality is that many customers enter and exit the nursing home throughout the month. The change of this rule will allow patients to pay for their Share of Cost only AFTER they have resided in a nursing home for one full calendar month. In the example stated before, there would no cause for refunds because the patient was not in the home for the entirety of either of the months of December or January. If the patient continued residence in the nursing home, they would begin paying their Share of Cost on February 1st.

The anticipated annual fiscal impact for this change is a total of \$161,058 (one hundred sixty one thousand, fifty eight dollars) of State funding. This increase will accommodate the portion of the costs for these services while the patient is in care for partial months.... and it will alleviate costly billing processes for providers, and refunding obstacles for patients who do not stay a full calendar month

I ask you to approve this pending rule as Final.

Thank you for your time today, I stand for questions.

AMENDED AGENDA #2
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, January 20, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
<u>Docket No. 16-0208-1401</u>	Vital Statistics Rules	James Aydelotte
<u>Docket No. 16-0501-1401</u>	Use and Disclosure of Department Records	James Aydelotte
<u>Docket No. 16-0303-1401</u>	Rules Governing Child Support Services	Kandee Yearsley
<u>Docket No. 16-0304-1401</u>	Rules Governing the Food Stamp Program in Idaho	Kristen Matthews
<u>Docket No. 16-0612-1401</u>	Rules Governing the Idaho Child Care Program (ICCP)	Ericka Rupp
<u>Docket No. 16-0322-1401</u>	Residential Care or Assisted Living Facilities in Idaho	Tamara Prisock

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, January 20, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson (Lodge), Nuxoll, Hagedorn, Tippets, Lee, Schmidt and Lacey

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Health and Welfare Committee (Committee) to order at 3:04 p.m.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin for rules review.

DOCKET NO. 16-0208-1401 **James Aydelotte**, State Registrar and Chief of Bureau of Vital Records (Bureau), Health Statistics, Public Health Division, Department of Health and Welfare (Department), reviewed **Docket No. 16-0208-1401**, Rules Pertaining to Vital Statistics. The proposed rule increases most of the Bureau's fees, due to increased overhead. The most significant increase is for a certified copy of a vital record, from \$13 to \$16 per certified copy or search. **Mr. Aydelotte** reviewed each requested increase and noted that, even with these changes, Idaho's certificates would still be less expensive than Nevada, Oregon, Washington and Utah.

Mr. Aydelotte asked the Committee to approve **Docket No. 16-0208-1401** and stood for questions.

MOTION: **Chairman Hagedorn** moved to approve **Docket No. 16-0208-1401**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0501-1401 **Mr. Aydelotte** reviewed **Docket No. 16-0501-1401**, Use and Disclosure of Department Records, and referred the Committee to page 168 of the rules review book. This rule change requests approval to conduct what is known as fact-of-death verifications, which differ slightly from the verifications that are currently performed. He said the rule is written to limit fact-of-death verifications to Idaho state agencies and entities seeking to determine or protect an individual's property rights.

Mr. Aydelotte asked the Committee to approve **Docket No. 16-0501-1401** and stood for questions.

Senator Tippets expressed concern with the language and asked if the wording could be tightened. **Mr. Aydelotte** explained that the rule, as written, ensures that everyone who uses the system must be approved and applies only to individuals seeking protection. He said the Department is always willing to look at improving the wording.

MOTION: **Senator Schmidt** moved to approve **Docket No. 16-0501-1401**. **Senator Tippets** seconded the motion. The motion passed by **voice vote**.

**DOCKET NO.
16-0303-1401**

Kandee Yearsley, Bureau Chief, Child Support Program, Department of Health and Welfare (Department), reviewed **Docket No. 16-0303-1401**, Rules Governing Child Support Services. The rule updates statutory references, provides definitions for the term's obligor, obligee, and motor vehicle license and clarifies the factors to be considered in license suspension proceedings. **Ms. Yearsley** said the rule also deletes an outdated form in the appendix and replaces it with a link to the current form on the Department's website.

Ms. Yearsley reviewed the changes in detail and asked the Committee to approve **Docket No. 16-0303-1401**.

Senator Nuxoll asked for clarification on the wording related to obligor funds, which she said was confusing. **Ms. Yearsley** said federal requirements prevent the Department from taking some funds from the obligor and the wording had not changed.

Senator Lee asked about contempt of court. **Ms. Yearsley** said contempt is the Department's last option.

Senator Hagedorn expressed concern that the courts target the obligor immediately. **Ms. Yearsley** said this occurrence is rare and is handled on a case-by-case basis.

MOTION:

Senator Nuxoll moved to hold **Docket No. 16-0303-1401** in Committee for time certain.

**SUBSTITUTE
MOTION:**

Senator Tippets moved to approve **Docket 16-0303-1401**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

**DOCKET NO.
16-0304-1401**

Kristen Matthews, Food Stamp Program, Department of Health and Welfare, reviewed **Docket No. 16-0304-1401**, Rules Governing the Food Stamp Program in Idaho. This docket clarifies violations in regulations which include buying, selling, stealing or trading. **Ms. Matthews** asked the Committee to approve the docket and stood for questions.

Committee members asked for clarification on drug trafficking, firearms sales, and wording to include date of review. **Chairman Heider** approved of the rule change, which he said is vital to control violations.

MOTION:

Senator Nuxoll moved to approve **Docket No. 16-0304-1401**. **Senator Hagedorn** seconded the motion. The motion passed by **voice vote**.

**DOCKET NO.
16-0612-1401**

Ericka Rupp, TANF Program Manager, Department of Health and Welfare, reviewed **Docket No. 16-0612-1401**, Rules Governing the Idaho Child Care Program. The rule was published as a temporary rule effective November 1, 2013 and was published in the January 2014 Idaho Administrative Bulletin. The Department states that its former copay structure did not comply with federal regulation because it was based upon a percentage of the cost of child care. To comply with federal requirements, copays must be income based. This rule bases copayment upon family income.

This rule also distinguishes between the copay requirements for postsecondary students and high school or GED students. Specifically, postsecondary students who do not work ten or more hours per week will be required to pay their own copayment. There is no fiscal impact associated with this rulemaking.

Ms. Rupp asked the Committee to approve **Docket No. 16-0612-1401** and stood for questions.

MOTION:

Chairman Heider moved to approve **Docket No. 16-0612-1401**. **Senator Lacey** seconded the motion. The motion passed by **voice vote**.

**DOCKET NO.
16-0322-1401**

Tamara Priscock, Administrator, Division of Licensing and Certification, Department of Health and Welfare (Department), reviewed **Docket No. 16-0322-1401**, Rules Pertaining to Residential Care or Assisted Living Facilities in Idaho. **Ms. Priscock** said the primary purpose of a residential care or assisted living facility in Idaho is to provide a humane, safe, and homelike living arrangement for adults who need assistance with activities of daily living and personal care. This rule change is to update licensing requirements in response to requests from living facility operators and updates standards of care. This rulemaking meets best practice and current technology standards while maintaining the health and safety of residents.

Ms. Priscock concluded by asking the Committee to approve **Docket No. 16-0322-1401** and stood for questions.

Committee members posed questions and received answers on concerns that included licensing requirements, facility providers and staffing.

MOTION:

Senator Nuxoll moved to approve **Docket No. 16-0322-1401**. **Senator Schmidt** seconded the motion. The motion passed by **voice vote**.

**PASSED THE
GAVEL:**

Vice Chairman Martin passed the gavel back to Chairman Heider.

ADJOURNED:

There being no further business, **Chairman Heider** adjourned the meeting at 4:36 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, January 21, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Docket No. 15-0202-1401	Vocational Rehabilitation Services	Greg Metsker
Docket No. 16-0317-1401	Medicare/Medicaid Coordinated Plan Benefits	Matt Wimmer
Docket No. 16-0310-1401	Medicaid Enhanced Plan Benefits	Matt Wimmer
Docket No. 16-0311-1401	Rules Governing Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID)	Debby Ransom
Docket No. 16-0311-1402	Intermediate Care Facilities for People with Intellectual Disabilities (ICF/ID)	Debby Ransom
Docket No. 19-0101-1401	Rules of the Idaho State Board of Dentistry	Susan Miller

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, January 21, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Nuxoll, Hagedorn, Tippets, Lee, Schmidt, and Lacey

ABSENT/EXCUSED: Senator Johnson (Lodge)

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: Chairman Heider convened the meeting at 3:00 p.m.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin for the rules review.

DOCKET NO. 15-0202-1401 **Greg Metsker, Commission for the Blind** , asked the Committee to reject this rule because changes in federal laws render this rule change null and void.

Vice Chairman Martin asked if the federal changes are wrong for Idaho.

Mr. Metsker replied that he did not have an answer to that question, but it was the opinion of the Vocational Rehabilitation Services to operate under the current rules until guidelines from the federal government are received.

MOTION: **Senator Hagedorn** moved to reject **Docket No. 15-0202-1401** . The **Senator Lacey** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0317-1401 **Matt Wimmer**, Medicare Bureau Chief, Department of Health and Welfare (Department), took the podium to explain the rule changes for **Docket No. 16-0317-1401**, Medicare/Medicaid Coordinated Plan Benefits. He referred the Committee to pages 136-142 of the electronic rules review book. He said the rules in this docket are being amended to support a more comprehensive managed care approach for Medicaid participants who are also eligible for Medicare.

Mr. Wimmer explained that the change will allow Medicaid participants to opt in to a managed care program that covers all benefits rather than only outpatient benefits. This simplifies coverage and allows participants to choose either Medicaid managed care or the State administered Medicaid plan. The Department sought public input and received no comments.

Mr. Wimmer said the changes are cost-neutral; there is no anticipated fiscal impact to the General Fund.

Mr. Wimmer asked the Committee to adopt this pending rule and stood for questions.

Senators Schmidt and **Tippets** asked questions related to specific Medicare services as a result of the changes. **Mr. Wimmer** answered the questions to the Committee's satisfaction.

Vice Chairman Martin asked if there were questions or comments from the audience; there were none.

MOTION: **Senator Schmidt** moved that the Committee adopt **Docket No. 16-0317-1401**. **Senator Tippets** seconded the motion. The motion carried by **voice vote**.

**DOCKET NO.
16-0310-1401**

Mr. Wimmer next presented **Docket No. 16-0310-1401**, relating to Medicaid Enhanced Plan Benefits, and referred the Committee to pages 81-106 in the Pending Rules book. He said this rule change has two purposes: (1) It defines the parameters for dental benefits for Medicaid enhanced plan participants in accordance with HB 395; and (2) it defines conditions for coverage of community supported employment benefits for developmentally disabled participants in accordance HB 476, 2014.

Mr. Wimmer explained that the change restores access to dental services that reflect evidence-based practices for adult participants with disabilities or special health needs. The new rules also create an exception review process allowing budget modifications for community supported employment for developmentally disabled individuals

The rules were drafted under negotiated rulemaking through a workgroup consisting of representatives from Medicaid, the Idaho Council on Developmental Disabilities, Disability Rights of Idaho, the Employment First Consortium, Vocational Rehabilitation, and other stakeholders.

Public hearings resulted in just one brief comment in support of the rules; no other comments were received during the comment period.

Fiscal impact to the General Fund is estimated at \$1.4 million for the dental benefits and \$235,000 for the community supported employment benefits. The costs for the dental benefits are expected to be fully offset by reductions in utilization of hospital and emergency room benefits related to dental care needs.

Mr. Wimmer asked the Committee to approve the rule changes and stood for questions.

Mr. Wimmer answered the questions posed by the Committee, which primarily concerned the reinstatement of benefits that had been cut during the recession.

MOTION:

Senator Hagedorn moved that the Committee adopt **Docket No. 16-0310-1401**. The motion was seconded by **Chairman Heider**. The motion carried by **voice vote**.

Vice Chairman Martin recognized Debby Ransom, Chief for the Department of Health and Welfare's Bureau of Facility Standards in the Division of Licensing and Certification.

**DOCKET NO.
16-0311-1402**

Ms. Ransom introduced herself and presented **Docket No. 16-0311-1402**, relating to Intermediate Care Facilities for People with Intellectual Disabilities. She referred the Committee to page 109 in the Pending Rules Review book and explained the docket is a rewrite of the chapter of rules governing Intermediate Care Facilities for individuals with Intellectual Disabilities (ICFs/ID). The rule in this chapter deals with State licensure of ICFs/ID.

Ms. Ransom said these rules had not been updated since the 1980s and many sections are no longer relevant. This alignment results in a streamlined set of requirements for this type of facility for both State licensure and for federal Medicaid certification. She said public hearings were held on the changes and no comments were received during the comment period. The rule docket was presented to the Board of Health and Welfare and passed with unanimous support.

Ms. Ransom said aligning State licensing requirements with federal certification requirements resulted primarily in updating terminology and references and reorganizing the chapter with a few more substantive changes. These changes include (1) administrators must have experience with the ICF/ID program before managing this type of facility, and (2) the use of painful or noxious stimuli or enclosures to manage client behavior is prohibited). The rule change also incorporates by reference the National Fire Protection Association's Life Safety Code as well as IDAPA 07.03.01, Rules of Building Safety.

Ms. Ransom asked the Committee to approve **Docket No. 16-0311-1402** and stood for questions.

Senator Nuxoll asked what are the major changes between 1980 and this one, other than technical? **Ms. Ransom** stated the 1980 version is outdated and not consistent with best practice needed to serve individuals with disabilities. This will bring it current, align providers with one set of requirements, and bring them up to current best standards. **Senator Nuxoll** followed up, asking which best practices will be better. **Ms. Ransom** stated the best practices center around managing and working with individuals to become as independent as possible. Additionally learning to manage behaviors without drugs or restrictive programs.

Chairman Heider asked about the housing standards; were there any that needed to come into compliance, did any of them have to close or if we had to build new ones. **Ms. Ransom** stated no, this provider population is an example of what providers should be doing. We have already been working with, and meeting the Federal requirements, so we have had no closures. **Chairman Heider** thanked Ms. Ransom and stated it was important to have on record that we have updated the standards, but that we were already up to standard. **Ms. Ransom** stated this group is exceeding it and she is pleased to be here with these rules.

Vice Chairman Martin asked if there were any costs to have, or meet these current standards. **Ms. Ransom** replied no there is not.

Senator Hagedorn recommended that a date be used for better clarification when referencing CFRs or other materials.

Senator Tippetts posed a number of questions for Ms. Ransom, including size of a facility and resident limitations. **Ms. Ransom** said the federal government had determined that housing residents in a large institution-like facility is not the best practice because it is not a normal environment for an individual.

Senator Tippetts asked about the alignment of State and federal codes; electrical inspection practices; meaning of "outside services"; bathroom placement; and if the Department has authority to revoke a license whether or not it potentially endangers safety. He commented that he was not comfortable in drafting a rule that is more broad than its intention.

Vice Chairman Martin asked about meeting State code restrictions. **Ms. Ransom** said local jurisdictions implement the codes and the Department works closely with the State in meeting those code restrictions. **Senator Hagedorn** asked about the hearing process and incorporation of suggestions. **Ms. Ransom** outlined the process, which includes quarterly conference calls and in-person meetings to incorporate suggestions. She also explained why an update to the sprinkler systems were required when a change in ownership of a facility occurs.

Vice Chairman Martin asked if there questions from the audience. There being none, he called for a motion.

MOTION:

Chairman Heider moved that the Committee adopt **Docket No. 16-0311-1402**. The motion was seconded by **Senator Hagedorn**. The motion carried by **voice vote**.

**DOCKET NO.
16-0311-1401**

Ms. Ransom referred the Committee to page 107 in the Pending Rules Review book. She explained that Rule **Docket No. 16-0311-1401** is a repeal of the chapter of rules governing intermediate care facilities for individuals with intellectual Disabilities.

Ms. Ransom said a public hearing was held and no comments were received during the comment period. She asked the Committee to adopt **Docket No. 16-0311-1401** and stood for questions. The Committee had no questions.

MOTION:

Senator Tippetts moved that the Committee adopt **Docket No. 16-0311-1401**. **Senator Heider** seconded the motion. The motion carried by **voice vote**.

**DOCKET NO.
19-0101-1401**

Susan Miller, Board of Dentistry, took the podium to present **Docket No. 19-0101-1401**, Rules of the Idaho State Board of Dentistry. The proposed rule clarifies the requirements for administering sedatives to patients in order to be consistent with standards set by the American Dental Association. Additionally, the proposed rule provides clarification regarding facility requirements, records, and patient monitoring. The rule is consistent with the Board's authority under Idaho Code § 54-912. There is no negative impact to the General Fund. The Board of Dentistry conducted negotiated rulemaking.

Ms. Miller asked the Committee to approve adoption of the rule changes and stood for questions.

Senator Schmidt asked for elaboration on the pediatric life support course.

Ms. Miller replied that the course would be similar to a general pediatric dental course. Referring to sedation, **Senator Hagedorn** asked if pediatric dentists are allowed to performed surgery in the office. **Ms. Miller** said the rule doesn't change current practices; pediatric dentists are trained and qualified to provide sedation in the office.

MOTION:

Senator Schmidt moved that the Committee adopt **Docket No. 19-0101-1401**. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

**PASSED THE
GAVEL:**

Vice Chairman Martin returned the gavel to Chairman Heider.

ADJOURNED:

There being no further business, **Chairman Heider** thanked the presenters and Committee members and adjourned the meeting at 4:30 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, January 22, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Docket No. 16-0507-1401	DEPARTMENT OF HEALTH AND WELFARE The Investigation and Enforcement of Fraud, Abuse, and Misconduct	Lori Stiles
Docket No. 16-0506-1401	Criminal History and Background Checks	Fernando Castro
Docket No. 16-0601-1401	Child and Family Services	Falen LeBlanc
Docket No. 16-0733-1401	Adult Mental Health Services	Casey Moyer
Docket No. 23-0101-1401	BOARD OF NURSING Rules of the Idaho Board of Nursing	Sandra Evans

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Smyser(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, January 22, 2015
TIME: 3:00 P.M.
PLACE: Room WW54
MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Hagedorn, Lacey, Lee, Nuxoll, Schmidt and Tippetts
ABSENT/EXCUSED: Senator Lodge
NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.
CONVENED: **Chairman Heider** called the meeting to order at 2:59 p.m. He welcomed everyone and let them know the Committee was on rules and would continue rules next week.
PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin.
DOCKET NO. 16-0507-1401 **Lori Stiles**, Investigations Supervisor for the Department of Health and Welfare (DHW), Medicaid Program Integrity Unit (Unit) of the Bureau of Audits and Investigations (Bureau), presented **Docket No. 16-0507-1401**, The Investigation and Enforcement of Fraud, Abuse, and Misconduct.

Ms. Stiles said their staff audited Medicaid providers to ensure they were complying with Medicaid rules and regulations. Last fiscal year they completed 262 audits, identified \$3.2 million in overpayments and penalties, and recovered nearly \$2.7 million. This docket would add a new section of rules to cover reinstatement procedures for individuals or entities that have been excluded from Idaho's Medicaid program. The rule provides the conditions, a timeline for submitting an application, how to request, and where to return the required documents. If an individual or entity was denied reinstatement, they can reapply a year after the date the denial decision was final. Section 300 of the rules was amended to add reinstatements as an action that required notification to the Office of the Inspector General (OIG). A negotiated rulemaking meeting was held July 10, 2014, in Boise, Idaho. No one attended and no written comments were received. This rule had no anticipated fiscal impact.

Ms. Stiles asked the Committee to approve **Docket No. 16-0507-1401**.

Senator Schmidt asked why no time frame was given for DHW to issue a written decision granting or denying requests. **Ms. Stiles** replied they intentionally kept the time frames out of this rule because there was a time frame to respond in the Unit's policies and procedures. No one had requested reinstatement yet, so they had not been able to go through the entire process.

Senator Nuxoll asked Ms. Stiles to explain Sections h. and 02, on page 173. **Ms. Stiles** responded when a provider, individual, or institution was excluded from the Medicaid program, if they continued to work as an employee or contractor for anyone that was receiving Medicaid funds while they were excluded, they would not be reinstated because they did not comply with the exclusion. **Ms. Stiles** further responded that an individual or institution was allowed to apply for reinstatement approximately four months before the end of the exclusion period because there

was a time lapse between the time they filled out the application and when the Board met to decide whether to approve or deny. It gave applicants an opportunity to start near the time their exclusion period was ending. **Senator Nuxoll** asked where the \$2.7 million in overpayments and penalties went. **Ms. Stiles** replied a portion helped fund the Medicaid Program Integrity Unit, a portion paid the federal share of the overpayments, and the majority went into the General Fund.

Vice Chairman Martin asked Ms. Stiles to explain the comment that no one had requested reinstatement. **Ms. Stiles** responded because federal exclusion requirements gave providers an opportunity to be reinstated through the OIG, providers had not been going through a reinstatement process with the State. They could start providing Medicaid services without the State's approval, so DHW produced a policy and procedure for reinstatement and put it in the Medicaid newsletter in June 2013. This docket would put it in the rules.

MOTION: **Senator Lacey** moved to approve **Docket No. 16-0507-1401**. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 16-0506-1401 **Fernando Castro**, Supervisor for the Criminal History Unit (Unit) of the Bureau of Audits and Investigations (Bureau) presented **Docket No. 16-0506-1401**, Criminal History and Background Checks.

Mr. Castro reported the Unit had completed nearly 23,000 background checks every year. He said the Unit screened employees of providers and individuals that participated in DHW programs such as foster care, adoption, and certified family homes. Each year, approximately 300 applicants are either denied or voluntarily withdraw because of disqualifying elements in their background checks. **Mr. Castro** explained the rule change incorporated several adjustments that supported other DHW rule changes which repealed, added, or changed background check requirements for certain classes of individuals.

DHW did not hold formal negotiated rulemaking meetings with their stakeholders for this docket because it was not feasible to conduct such meetings in time to have temporary rules in place to meet legislative intent and the statutory requirements that changed those rules themselves. However, they actively and constantly listened to their stakeholders' concerns through other mediums such as customer service surveys, quarterly newsletters, direct feedback to the Unit, and by including them in the development of their website. He explained the proposed changes and gave references to where those changes were in the docket.

Senator Nuxoll asked if some of the changes were made due to DHW's discretion. **Mr. Castro** responded he did not believe so. When any background check rules were changed, they had to change this one to support that requirement. **Senator Nuxoll** asked if that was also true about the rule they deleted. **Mr. Castro** replied it was not at the discretion of DHW as far as he understood. It was an attempt to keep the language concurrent in both communications. **Senator Nuxoll** said on page 23, it says the employer must print the clearance within 14 days of the clearance being accessible on DHW's website. She asked if that was enough time. **Mr. Castro** responded DHW felt it was enough time because the system sent an automatic notice to an employer as soon as their candidate was cleared. They found employers would view the email without opening and reading the attached background record. This change was an effort to tell employers to open the report to look at what was found. **Senator Nuxoll** inquired about the change in 300.02.B on page 24. **Mr. Castro** said the background check system allowed for one background check to be used across several parts of the industry. In order to view the results and see who was available for an interview, an employer had to attach themselves to the person in the system. This rule change told employers to

make sure they attached themselves to the candidate of their choice in the system.

Senator Hagedorn commented on page 23, Section 140.01, where the language was deleted that a fee may be assessed when an individual missed a scheduled appointment. He said it spoke very well of Mr. Castro and DHW for following up on a Committee recommendation to take that action.

MOTION:

Senator Hagedorn moved to approve **Docket No. 16-0506-1401**. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**.

**DOCKET NO.
16-0601-1401**

Falen LeBlanc, Program Specialist, Division of Family and Community Services (Division), DHW, presented **Docket No. 16-0601-1401**. She described the Chafee Foster Care Independence Program Act which was passed by Congress in 1999 to provide services to promote a more successful transition to adulthood for older youth leaving foster care.

Ms. LeBlanc reported DHW made payments for driver's training, permit, and license for a child in their legal custody when it was part of the child's Independent Living Plan. This rule change would allow the DHW to reimburse a licensed foster parent for the cost of vehicle insurance for the foster child. **Ms. LeBlanc** said the changes would improve recruitment and retention of foster parents, increase placement options for older youth, and encourage life skills and normalization of eligible foster children by allowing them to become drivers while in foster care where they had family support and direction. Costs would be paid from the existing Chafee Independent Living appropriation. Approximately 100 foster children would be able to access the reimbursement for an estimated maximum annual cost of \$132,000. Negotiated rulemaking was not conducted since this docket conferred a benefit.

Senator Nuxoll asked when the Division would have the authority to decide to do something like this and use more money. **Ms. LeBlanc** said the funding was specific to the foster youth population. The Division would offer vehicle insurance reimbursement one-on-one with the foster parents and the young person in foster care when the young person was ready to drive. It would be in addition to the ongoing life skills training DHW already provided. **Senator Nuxoll** asked how they would get the authority to use these funds even though the Finance Committee did not give them the authority to use the funds. **Ms. LeBlanc** deferred to Dave Taylor, Deputy Director, DHW. **Mr. Taylor** said DHW had a reprioritization of their current appropriation and it would not incur additional costs. The benefit would only be offered as funds were available.

Senator Hagedorn asked how many older children were in the foster care program in Idaho. **Ms. LeBlanc** replied 269 people between the ages of 15 and 18 were in foster care in the Independent Living Program. They had 1,259 young people total in foster care.

Senator Lee asked how many foster children would still be in foster care at age 21 and if this rule change would apply to people in foster care past the age of 18. **Ms. LeBlanc** responded this rule would only apply to the 15- to 18-year-olds who were currently in foster care. Once they turned 18 they would be able to insure themselves. There was a voluntary program for that which was very specific.

MOTION:

Senator Nuxoll moved to approve **Docket No. 16-0601-1401**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

**DOCKET NO.
16-0733-1401**

Casey Moyer, Program Manager, Division of Behavioral Health, DHW, presented **Docket No. 16-0733-1401** regarding Adult Mental Health (AMH).

Mr. Moyer explained the Division of Behavioral Health's AMH program statutorily mandated populations and prioritization methods. He said an update was needed so the rules would reflect the changing environment and best practices to include reference to the Diagnostics and Statistics Manual Fifth Edition, improve efficiency and access through an ongoing quality assurance process, update terminology, and reflect non-customer internal program process changes. A new subsection addressed consumers' rights and responsibilities related to participation in treatment and affirmed the clients' rights to humane treatment, choice and access while they were a part of the AMH program. **Mr. Moyer** stated there was no negotiated rulemaking because these rules were program and staff operational policies. He said there would be no adverse financial impact to the program or ability to meet statutory obligations. Approval of these rules would help DHW improve the quality of care.

Senator Tippetts asked Mr. Moyer to deliver the message to DHW that the Committee would like to see negotiated rulemaking. **Senator Tippetts** also asked that the wording on item i., page 189, be changed from requiring the client or legal guardian to sign the treatment plan to say DHW would attempt to get the signatures on treatment plans. **Mr. Moyer** responded signatures were a means to verify that the client was involved in the treatment plan, and if a client was unable to sign there were alternate documentation mechanisms for the lack of signature.

Senator Tippetts asked Mr. Moyer to explain why treatment plan renewals were required every 12 months. **Mr. Moyer** replied treatment plans were required to determine if treatments were effective and utilizing the right resources. The 12-month requirement was the minimum.

Senator Nuxoll asked if 120-day treatment plan reviews were different than annual treatment plan renewals. **Mr. Moyer** replied yes; reviews and renewals often took place simultaneously because changes may be needed to a treatment plan as a result of a review. **Senator Nuxoll** asserted that negotiated rulemaking is very important in order to make a judgment on rule changes based on whether anyone had problems with the change.

Senator Heider asked if Optum was a subcontractor to the contract. **Mr. Moyer** replied Optum Idaho was separate from the AMH program operated by the Division of Behavioral Health. Optum operated under Medicaid rules.

MOTION:

Senator Hagedorn moved to approve **Docket No. 16-0733-1401**. **Senator Tippetts** seconded the motion. **Senator Nuxoll** asked to be recorded as voting nay. The motion carried by **voice vote**.

**DOCKET NO.
23-0101-1401**

Sandra Evans, Executive Director, Idaho Board of Nursing, presented **Docket No. 23-0101-1401**, Pending Rules of the Board of Nursing.

Ms. Evans reported the 2014 Legislature amended the Board of Nursing's statute to include as grounds for discipline, sexual conduct or sexual exploitation by a nurse of a current or, in certain situations, a former patient. She said **Docket No. 23-0101-1401** provides clarity to the statutory provisions by identifying what constitutes prohibited conduct by a nurse, defining terms, and otherwise implementing provisions of the law. Public notice of the intent to promulgate rules and negotiated rulemaking was published on June 4, 2014. Written and oral comments were received during a public meeting held on July 17 and during the prescribed comment period. Comments received were in support of the proposed

rule. **Ms. Evans** said there would be no fiscal impact resulting from implementation of this rule.

Senator Tippetts said he had expected these rules to be very difficult to write and congratulated the Board of Nursing for getting it right and doing a good job.

MOTION: **Senator Heider** moved to approve **Docket No. 23-0101-1401**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Martin passed the gavel back to Chairman Heider.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:05 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Paula Tonkin
Assistant Secretary

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, January 26, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
	IDAPA 27 - BOARD OF PHARMACY	
Docket No. <u>27-0101-1401</u>	Rules of the Idaho State Board of Pharmacy	Mark Johnston R.Ph., Executive Director Board of Pharmacy
Docket No. <u>27-0101-1402</u>	Rules of the Idaho State Board of Pharmacy	Mark Johnston R.Ph., Executive Director Board of Pharmacy
Docket No. <u>27-0101-1403</u>	Rules of the Idaho State Board of Pharmacy	Mark Johnston R.Ph., Executive Director Board of Pharmacy
Docket No. <u>27-0101-1404</u>	Rules of the Idaho State Board of Pharmacy	Mark Johnston R.Ph., Executive Director Board of Pharmacy
Docket No. <u>27-0101-1405</u>	Rules of the Idaho State Board of Pharmacy	Mark Johnston R.Ph., Executive Director Board of Pharmacy

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Smyser(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, January 26, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson (Lodge), Nuxoll, Hagedorn, Tippetts, Lee and Schmidt

ABSENT/ EXCUSED: Senator Lacey

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Health and Welfare Committee (Committee) to order at 3:00 p.m. and welcomed Senator Kim Johnson, sitting in for Senator Lodge.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin for rules review.

DOCKET NO. 27-0101-1401 **Mark Johnston**, Executive Director of the Board of Pharmacy (Board), addressed **Docket No. 27-0101-1401**, Rules of the Idaho State Board of Pharmacy. The proposed rule would allow biosimilar products to be substituted for a prescribed biological product in order to be consistent with federal law. There is no negative fiscal impact on the General Fund. Negotiated rulemaking was conducted, and the rule is consistent with the Board's authority under Idaho Code § 54-1717.

Mr. Johnston explained that Congress has created a new pathway for drug approval, collectively known as biosimilars, and outlined the makeup of biological products compared to most drugs. He said federal law allows for a provision that goes beyond simply approving a biosimilar, by determining that the licensed biosimilar is interchangeable with the referenced biological product.

Mr. Johnston said if this rule is defeated via concurrent resolution, biosimilar substitution will not be allowed in Idaho, thus making Idaho more restrictive than the federal government. He said this promulgation establishes the Idaho parameters for biosimilar interchange and is supported by groups such as Blue Cross of Idaho, Regence Blue Shield of Idaho, Select Health Plans, and others.

Mr. Johnston read the changes to the rule word for word and said the Board has received no opposition to the language. He said notification requirements have been raised, but he emphasized Idaho has years to determine if notification should be required and what such a requirement might look like. He concluded by asking the Committee to approve **Docket No. 27-0101-1401** and stood for questions.

Questions from the Committee centered mostly on notification requirements and cost savings, all of which were answered fully by Mr. Johnston.

Vice Chairman Martin called on those wishing to testify on **Docket No. 27-0101-1401**.

TESTIMONY: **Dr. Troy Rohn**, Professor, Boise State University, testified in opposition to **Docket No. 27-0101-1401**. He said he was in favor of biosimilars because of their therapeutic value and cost savings for consumers. However, he was in opposition to the rule as written because the wording did not contain notification requirements, which he said were necessary for patient safety, transparency and treatment plans.

Susan Holladay from Meridian, representing herself, testified in opposition to the rule because of lack of notification requirements to the physician. She said five family members are on biologics, and her experience confirms the patient and physician need to know if a prescription is substituted because of the potentially harmful consequences.

Tony Holladay from Meridian, representing himself, testified in opposition to the rule. He said as a person with rheumatoid arthritis, he has been pain-free for over a year because of biologics. He said, however, that it is vitally important for his physician to know when a substitution has been made.

Ken McClure, an attorney with Givens-Pursley, representing the Idaho Medical Association (IMA) and AmGen, testified in opposition to the rule. He distributed letters of opposition and graphs (see attachment 1). He said that IMA has urged the Board to give the physicians full knowledge about what is going on. He believes this is an important aspect missing from the rule.

Mr. McClure said biologics are used mostly in oncology, rheumatology, and dermatology. He said all national specialty societies of these physician groups have written letters to Legislators. All have asked that a mechanism be required for the substitution to be placed in the patient's medical chart.

Mr. McClure referred to the charts distributed to the Committee, which illustrated information on top biologics and biologic adverse event attribution without complete patient records. He said most biologic drugs are either injected or infused by a clinic or hospital but some do come from pharmacies, which can result in lack of information needed by the doctor. He referred to the handout from the Generic Pharmaceutical Association, which also supports the communication requirement.

Shad Priest, Director of Government Affairs, Regence Blue Shield and also representing Bridge Pan Health, Cambia Health Solutions, and Oneida County Rx, testified in support of **Docket No. 27-0101-1401**. He said these companies care about health care costs, and biosimilars are a tool to control prices through competition. He said the United States has one of the most stringent rules for new drugs and, because this is a class of medication that does not yet exist, there is time to refine the rule at a later date.

Pam Eaton, President and CEO, Idaho Retailers Association and Retail Pharmacy Council, testified in support of the rule. She said the FDA is extremely cautious, and biosimilars will help get costs under control.

TESTIMONY:

Stacey Satterlee, Director of Government Relations in Idaho, American Cancer Society, testified in opposition to the rule. She said the rule does not contain a requirement for patient and prescriber notification when a biosimilar substitution is made. She stressed that patients need to be more actively engaged in their treatments, and they can only be as effective as the information provided to them.

TESTIMONY:

Maral Farsi, representing CVS Health, Blue Cross of Idaho, and Pacific Source Health, testified in support of the rule, as adopted by the Board. She said notification is unnecessary and undermines the FDA exhaustive approval process.

Throughout all testimonies, the Committee asked questions and received detailed answers in response. The primary objection to the rule was the lack of wording that would require notification to a patient's physician when a biosimilar substitution is made. **Senator Hagedorn** also expressed concern about the wording "patient's medical records", which appeared to be at variance with the actual meaning "patient's medication records." **Mr. McClure** said this was a misprint, and it would be corrected.

Vice Chairman Martin reminded the Committee the vote would be on the wording as written.

MOTION: **Senator Nuxoll** moved to approve **Docket No. 27-0101-1401**. **Chairman Heider** seconded the motion. The motion passed by **voice vote**.

PASSED THE GAVEL: Vice Chairman Martin passed the gavel back to Chairman Heider.

ADJOURNED: **Chairman Heider** notified the Committee and audience the remaining dockets on the agenda would be rescheduled. He adjourned the meeting at 5:00 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant Secretary

STATEMENT



Statement Regarding the Idaho Board Pharmacy Rule (BOP) Rule with Respect to the Substitution of Interchangeable Biologics

January 19, 2015

Position: Pharmaceutical Research and Manufacturers of America (PhRMA) supports Idaho with respect to the substitution of interchangeable biologics but encourages the legislature to support doctor notification, an important patient protection.

PhRMA supports the BOP rule with respect to the substitution of interchangeable biologics. This rule will allow for the substitution of biologics deemed interchangeable by the Food and Drug Administration (FDA). Importantly, PhRMA encourages the requirement for pharmacists to notify the prescriber if a biosimilars substitution is made.

PhRMA represents innovative biopharmaceutical research and discovery companies devoted to advancing public policies in the U.S. and around the world that support innovative medical research, yield progress for patients today and provide hope for the treatments and cures of tomorrow. PhRMA companies spent an estimated \$51 billion in 2013 to discover and develop new medicines.

Understanding the distinction between a chemically synthesized prescription drug and a biologic is important when crafting state law to address pharmacy substitution practices. Unlike traditional medicines, which are chemically synthesized, biologic medicines are more complex and are manufactured from living organisms. A biosimilar product is highly similar to, but not the same as, its FDA-licensed reference biological medicine. Recent federal legislative and regulatory activity has created an abbreviated regulatory pathway for approving biosimilar products. Ensuring patient safety is essential in the implementation of the Biologics Price Competition and Innovation Act of 2009 (BPCIA) and the amendment of state substitution laws to permit the substitution of interchangeable biosimilars.

As written, the rule requires that because biosimilars will not be exactly the same as the reference biologic product, substitution should only occur when the FDA has designated a biologic product as interchangeable with the reference product. PhRMA appreciates the addition of several important patient protections, including:

- The prescriber should be able to prevent substitution. This ensures the prescribing practitioner, who is knowledgeable about a patient's specific health history and therapeutic regimen, has ultimate decision-making authority for patient care.
- The patient, or the patient's authorized representative, should, at a minimum, be notified of the substitution. Patients who are managing chronic conditions often have tried many



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January 16, 2015

Idaho House of Representatives
State Capitol Building
Health and Welfare Committee
P.O. Box 83720
Boise, Idaho 83702-9103

RE: Proposed Board of Pharmacy Biosimilars Rules 27-0101-1401

Dear Members of the Idaho House Health and Welfare Committee,

On behalf of the Coalition of State Rheumatology Organizations (CSRO), we respectfully request the Idaho House Health Committee reject the Board of Pharmacy Biosimilar Rules, unless it is amended to include post-dispensing prescriber notification.

CSRO is a national organization composed of 30 state and regional professional rheumatology societies formed in order to advocate for excellence in rheumatologic care and to ensure access to the highest quality care for patients with rheumatologic and musculoskeletal disease. Rheumatologists are entrusted with the safe care of patients with rheumatoid arthritis and other autoimmune diseases that require the careful choice of safe and effective pharmaceutical and biological therapies.

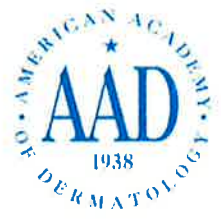
Rheumatologists are keenly aware of the dramatic long-term, life-changing clinical improvements that biological agents have on some of the most crippling and disabling conditions that affect Americans. These biologic response modifying agents are available for the treatment of rheumatoid arthritis and other autoimmune diseases and have a significant impact on improving our patients' quality of life, preventing disability, decreasing morbidity and lowering mortality.

In testimony before the Food and Drug Administration (FDA), Dr. Gregory Schimizzi, CSRO Treasurer, noted that there is not sufficient scientific understanding of biosimilars at this time to allow for an interchangeable biological product. As such, Dr. Schimizzi urged FDA to foreclose the interchangeability option until the science advances in this area because anything short of barring interchangeability would be detrimental to patient safety and would erode physician confidence in prescribing these medications.

Assuming that FDA does proceed with finding interchangeability for certain biosimilars, however, the current automatic substitution process used for generic medications in many states is inappropriate for biosimilars. As Dr. Schimizzi explained in his testimony, "The physician should always be involved in decisions regarding selection of the biological product a patient receives. Automatic retail substitution of biotech medicines is not appropriate. Currently, all State laws allow the pharmacist to substitute a less expensive generic product for the brand name product, and the determination of the ability to substitute such products is based on the nonproprietary name. In some states, like Pennsylvania, unless the prescriber signs or initials "brand necessary" or "brand medically necessary," the pharmacist is required by law to provide the generic form, unless the patient demands a brand name drug."

This approach cannot be applied to biosimilars, which are inherently far more complex products than generic drugs. No two patients are the same; in fact, sometimes two individuals who seem to have identical medical conditions "on paper"

January 17, 2015



Representative Fred Wood, Chair
Idaho House Health & Welfare Committee
700 West Jefferson Street
Boise, Idaho 83720

Subject: Oppose changes to 27.01.01.— Rules of the Idaho State Board of Pharmacy regarding biosimilar substitution

Dear Chairman Wood:

On behalf of the more than 13,500 members of the American Academy of Dermatology Association ("Academy"), I write in opposition to the changes proposed by the Idaho State Board of Pharmacy regarding biosimilar substitution. In accordance with the proposal, pharmacists would be authorized to substitute biosimilars for biologic drugs without notification to the health care provider. While we applaud the cost benefits that might occur from biosimilars, substituting a biosimilar absent the medical judgment of the patient's prescribing physician could be detrimental to patient safety. According to the Academy's *Position Statement on Generic Therapeutic and Biosimilar Substitution*, such communication should occur by the time of dispensing (see attached).

Dermatologists who treat severe psoriasis call the advent of biologic therapies a revolution. U.S. patents for these therapies expire in the next ten years, which will open the pathway for biosimilars. Manufacturing a biosimilar is much more complex than manufacturing generics for small molecule drugs. Because biologics are manufactured in living organisms, biosimilars are not exact replications of their reference biologic products. Due to this variability, a patient's response to a biosimilar may not always mirror the response to the reference drug. Even minor changes in the manufacturing process can significantly affect the efficacy of the biosimilar. For these reasons, patient substitution decisions for biosimilars should be carefully considered and should include a physician's medical judgment.

A proposal that does not require physician notification of the substitution at the time of dispensing could jeopardize patient safety and it implies that the risks associated with biosimilars are minimal. Further, the concern that notification would impede a patient's access to medication is not justified as most biologics are delivered via shipping to patients through specialty pharmacies as opposed to traditional medications that are purchased at a patient's local pharmacy.

In order to protect Idaho's patients, the Academy strongly opposes the current proposal that would eliminate the physician's role and medical judgment from patient care. The medical community would welcome an opportunity to work with

American Academy of Dermatology Association
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Mary Jo Richards
 Executive Director ISCO
 Owasso, OK

Re: BoP Biosimilar rule. Please table the rule until amended to include post-dispensing communication between pharmacists and prescribing physicians when biopharmaceutical products are replaced by biosimilar products.

Honorable Idaho Health and Welfare Committee members,

The Idaho Society of Clinical Oncology (ISCO) is comprised of 257 oncology physicians, mid-level healthcare providers, oncology nurses and practice administrators located throughout Idaho. ISCO was established to respond to the legislative and fiscal challenges of our member jurisdiction and to promote improved healthcare services to the community by sharing resources, information and common goals such as patient safety and affordable quality care.

ISCO physicians have been made aware of a proposed rule that is currently being considered that will allow pharmacists to substitute complex specialty medications, known as biologics, with biosimilar drugs without providing any notice or communication to the doctor.

Unlike conventional chemical drugs, biopharmaceutical products typically require the use of living biological host cells for their production. This includes the use of genetic engineering techniques for cloning of the appropriate genetic sequence into a plasmid or viral messenger system, followed by the creation of a host cell expression mechanism and scaling it up for large-scale protein production. The desired protein must then be isolated and purified from the cell culture medium, using purification techniques that maintain the protein's structural and functional integrity. The purified product must then be correctly formulated to ensure that it retains its biological activity up to patient delivery.

The large size and complexity of biopharmaceutical products mean that manufacturing is equally complex, and quality-control processes are vital because the expression of the same genetic construct in different host cell expression systems has a great impact on the final structure of the protein. Patient responses can depend on how a biologic is made. They are highly sensitive to their manufacturing and handling conditions, making them more difficult to create than common chemical drugs. Even something as simple as the altitude of a manufacturing facility can lead to changes in cell behavior and differences in the structure, stability or other quality aspects of the end product. Any of these differences have the potential to affect the treatment's safety, efficacy and/or shelf life, and to increase the risk of an unwanted immune response.

A new class of medications called "biosimilars" will be entering the marketplace in the near future and are touted to be therapeutically equivalent or interchangeable with biologics and are predicted to have a lower cost. However, unlike generic drugs that are identical copies of the original product, biosimilars, as the name implies, are similar but not identical to the pioneer biologic therapy. That slight difference can have huge implications for efficacy and patient safety.

ISCO's concern is that biosimilar manufacturers do not have access to the originator's molecular clone and original cell bank, nor to the exact fermentation and purification process, nor to the active drug substance. They do have access to the commercialized innovator product. Differences in impurities and/or breakdown products can have serious health implications.

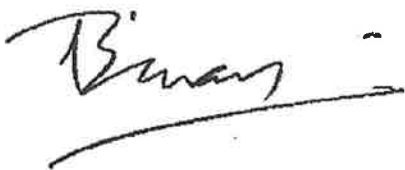
ISCO strongly recommends enforcing communication between the pharmacist, patient and oncologist when a biopharmaceutical product is replaced by a biosimilar product. There are ethical considerations and liability issues created when arbitrarily switching drugs used in the treatment of major or life-threatening conditions without informed consent of the patient or the primary caregiver's knowledge.

- Patient Safety - Biosimilars have the potential to create a different response within a patient's body than the original biologic product.
- Informed consent - An informed consent can be said to have been given based upon a clear appreciation and understanding of the facts, implications, and consequences of an action. This cannot be achieved if the pharmacist has switched drugs without the physician's knowledge.
- Physician liability - In cases where a patient is provided insufficient information to make an informed decision, serious ethical and liability issues arise. This is especially imperative when dealing with life-threatening diseases.
- Disjointed care - By personally and furtively switching cancer-fighting agents, pharmacists are removing the oncologist, the person primarily responsible for the treatment of the cancer patient, from the clinical therapeutic decision-making process.
- Monitor adverse events – Healthcare providers require complete and accurate medical records to refer to when treating patients, allowing them to track medications and make informed decisions regarding adverse events. Doctor notification is a simple measure that helps track whether patients are having adverse reactions to biopharmaceutical products vs. newly-introduced biosimilars.
- Efficacy - Oncologists cannot determine the efficacy of biosimilars if they do not know who is receiving them.

The end goal is to make sure that we have a workable system, and that patient safety is of the highest order. If we do not have a clear-cut ability to track individual products once they are marketed, it will be virtually impossible to get at the root cause of any problems that arise.

ISCO strongly recommends enforcing communication between pharmacists and primary care givers when biopharmaceutical products are replaced by biosimilar products.

Sincerely,

A handwritten signature in black ink, appearing to read "Binay", with a long horizontal line extending from the end of the signature.

Binay Shah, M.D.
President, Idaho Society of Clinical Oncology
Binay.shah@gmail.com



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January 16, 2015

Idaho House of Representatives
State Capitol Building
Health and Welfare Committee
P.O. Box 83720
Boise, Idaho 83702-9103
(Via electronic delivery)

RE: Letter of comment for Proposed Board of Pharmacy Biosimilar Rules 27-0101-1401

Dear Members of House Health and Welfare Committee:

On behalf of the American College of Rheumatology, **I would again like to express our concern regarding the proposed rules related to the prescription of biological products and interchangeable biological products.** We believe a critical aspect of this issue is the timely notification of changes in patient therapies, which helps to ensure patient safety. In the absence of a requirement to notify in advance of dispensation, notification as early as possible will help to ensure that if there is an adverse event or potentially dangerous immune response, the provider is aware of what has changed. Because of this important consideration, **we respectfully ask that the rules be amended to include prior notification or at a minimum require notification within three days of the prescription being filled.**

Like with innovative biologic products, predicting how a patient will respond to a biosimilar or interchangeable biologic may be challenging. Safety is a critical concern with any of these products that directly impact the immune response in a patient. It is possible that small variations from the original biologic may result in an immune response or other potentially serious side effect, which could result in emergency room visits or hospitalizations. It is very encouraging that Idaho has an opportunity to have guidelines in place to ensure patient safety through appropriate provider engagement and notification, and we applaud you and your colleagues.

The ACR appreciates the opportunity to provide these comments. We are committed to advancing excellence in the care of patients with arthritis and rheumatic and musculoskeletal diseases, which includes serious conditions such as rheumatoid arthritis and other debilitating and potentially-disabling rheumatic diseases. If we may assist you with any additional information or questions, please contact Starla Tanner at stanner@rheumatology.org or by telephone at (404) 633-3777.

Thank you very much for the work you do and for your consideration of this request.

Sincerely,

E. William St.Clair, MD
President, American College of Rheumatology



Eric Miltstead
Director

Legislative Services Office

Idaho State Legislature

Serving Idaho's Citizen Legislature

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Health & Welfare Committee and the House Health & Welfare Committee

FROM: Legislative Research Analyst - Elizabeth Bowen

DATE: September 30, 2014

SUBJECT: Board of Pharmacy

IDAPA 27.01.01 - Rules Pertaining To The Idaho State Board of Pharmacy - Proposed Rule (Docket No. 27-0101-1401)

IDAPA 27.01.01 - Rules Pertaining To The Idaho State Board of Pharmacy (Fee Rule) - Temporary and Proposed Rule (Docket No. 27-0101-1402)

IDAPA 27.01.01 - Rules Pertaining To The Idaho State Board of Pharmacy - Proposed Rule (Docket No. 27-0101-1403)

IDAPA 27.01.01 - Rules Pertaining To The Idaho State Board of Pharmacy - Proposed Rule (Docket No. 27-0101-1404)

IDAPA 27.01.01 - Rules Pertaining To The Idaho State Board of Pharmacy - Proposed Rule (Docket No. 27-0101-1405)

(1) IDAPA 27.01.01 - Rules Pertaining To The Idaho State Board of Pharmacy - Proposed Rule (Docket No. 27-0101-1401)

The Board of Pharmacy submits notice of proposed rulemaking at IDAPA 27.01.01. The proposed rule would allow biosimilar products to be substituted for a prescribed biological product, in order to be consistent with federal law. There is no negative fiscal impact on the state general fund. Negotiated rulemaking was conducted. The rule is consistent with the Board's authority under Section 54-1717, Idaho Code.

(2) IDAPA 27.01.01 - Rules Pertaining To The Idaho State Board of Pharmacy (Fee Rule) - Temporary and Proposed Rule (Docket No. 27-0101-1402)

The Board of Pharmacy submits notice of temporary and proposed rulemaking at IDAPA 27.01.01. The temporary and proposed rule defines outsourcing facilities, creates a new registration category for outsourcing facilities, establishes a registration fee, and establishes practice standards for outsourcing facilities. The purpose of the temporary and proposed rule is to make Idaho's regulatory scheme consistent with the federal Drug Quality and Security Act. There is no apparent negative fiscal impact on the state general fund. Negotiated rulemaking was conducted. The rule is consistent with the Board's authority under Section 54-1717, Idaho Code.

Mike Nugent, Manager
Research & Legislation

Cathy Holland-Smith, Manager
Budget & Policy Analysis

April Renfro, Manager
Legislative Audits

Glenn Harris, Manager
Information Technology

Statehouse, P.O. Box 83720
Boise, Idaho 83720-0054

Tel: 208-334-2475
www.legislature.idaho.gov

Intro:

Page #228 in your pending rules book.

270101-1401. Congress has created a new pathway for drug approval. These new drugs are collectively known as biosimilars and, by federal law and this pending rule, they must be highly similar to a specific reference biological product that is already an FDA approved drug. Biological products are large complicated molecules, as compared to most drugs which are generally easier to manufacture. Biological products are produced by living cells, and slight variations may exist from batch to batch within the brand name manufacturing process. As these molecules are so complicated and it's impossible to make an exact replica of a slightly moving target, generic drugs can not be made. Drugs work in the body by attaching to receptor sites, and only a small portion of the large biological product attaches to the receptor site. Generally speaking, creating an exact replica of a biological product is not necessary, if the part that adheres to the receptor site fits correctly. Not only do biological products have to be proven highly similar to a specific reference biological product in order to gain FDA approval, but they have to be proven safe and effective. Generic drugs do not have to prove that they are safe and effective, as their reference product's drug studies are utilized for generic FDA approval. The FDA approval for biosimilars is certainly a rigorous one, and I'm not aware of any opposition to it.

Federal law allows for a provision that goes beyond simply approving a biosimilar... by determining that the licensed biosimilar is interchangeable with the referenced biological product. This docket of rules establishes the Idaho parameters for biosimilar interchange. Certain aspects of such interchangeability have become controversial.

Many states do not have to promulgate rules in order to substitute an FDA approved interchangeable biosimilar. Their rule language is more general, such as allowing substitution for “similar” drug products, which allows generic selection AND interchangeable substitution. Idaho’s generic selection is specific to products listed in the FDA’s Orange book. The FDA publishes all licensed biological products in the Purple Book. Therefore, rule promulgation is necessary in Idaho to allow substitution of FDA approved interchangeable biosimilars.

Efforts have been very successful in undermining the FDA biosimilar approval process, establishing fear that products that are only similar (and not exact) will potentially not work as well or cause potentially unwanted side effects. In reality, the FDA has established incredibly high standards for biosimilar interchangeability including:

- biosimilars can be expected to produce the same clinical result as the reference product in any given patient; and
- the safety and reduced efficacy risks of alternating or switching are not greater than with repeated use of the reference product.

The FDA is traditionally a VERY conservative agency. The Board trusts that the FDA will not approve interchangeability unless the products meet these extremely high standards.

The Board heard from patient advocacy groups and prescribing groups that utilize biological products at the Board’s two public negotiated rule making sessions. The Board also heard over 50 pieces of public comment on the topic, more than the Board received when rewriting our entire set of rules...78 pages...in 2012. Negotiated rulemaking works! The Board altered much of their draft language and then altered much of their proposed language, pursuant to public comment,

to produce the pending rules before you. Much of the comment received was in support of the Board's proposal, but more of it was opposed. Again, the Board trusts the rigorous process that Congress and the FDA developed for the approval of biosimilars.

Many biosimilars have been available in the European market for decades, so these are often not unproven drugs. Biosimilars are typically expensive, injectable drugs. The Rand Corporation predicts that biosimilars will lead to a \$44.2 billion dollar reduction in spending on biologic drugs in the United States over the next decade. Just last week an FDA panel unanimously approved the first biosimilar, and the FDA is expected to accept their report and license the first biosimilar in the United States later this year.

If this pending rule before you is defeated via concurrent resolution, biosimilar substitution will not be allowed in Idaho. We will be more restrictive than the federal government and we will not realize the full cost savings that biosimilars will provide. Thus, this promulgation is supported by groups like Blue Cross of Idaho, Regence Blue Shield of Idaho, Select Health, Pacific Source Health Plans, the National association of Chain Drug Stores, CVSHealth, Express Scripts, the Academy of Managed Care Pharmacy, the Pharmaceutical Care Management Association, The Idaho State Pharmacy Association, Idaho Retail Pharmacy Council, and Mylan. The Board of Pharmacy does not often consider the financial aspect of the law. Our job is to protect public safety, not to save the state and its citizens money, but when healthcare costs prevent care from being administered at all, cost becomes a public safety issue.

Back to the language within the docket in front of you. After defining the various terms that I have used today, you will find pending changes to rule 130: drug product substitution. I don't often read changes word

for word, but for such a big topic, the language is short, so I will this time.

04. Biosimilars. A pharmacist may substitute an interchangeable biosimilar product for a prescribed biological product if:

- a. The biosimilar has been determined by the FDA to be interchangeable and published in the Purple Book; ()
- b. The prescriber does not indicate by any means that the prescribed biological product must be dispensed; and ()
- c. The name of the drug and the manufacturer or the NDC number is documented in the patient medical record. ()

Opponents of this rule promulgation want to add, what the Board has determined to be an unneeded hindrance to FDA approved biosimilar interchangeability: What is referred to as “notification” or “communication”. These opponents will have you believe that without this provision a pharmacist will substitute an interchangeable biosimilar and the prescriber will not know what has been dispensed.

As previously mentioned, biologic drug therapy is very expensive. Third party payers, “insurance companies”, and Medicaid typically do not pay for biologic drug therapy without a prior approval process. One physician testified at one of our negotiated rulemaking sessions that the prior approval process is often 6 weeks long. Certainly a physician is notified of the drug to be dispensed during the lengthy prior authorization process by the third party payer.

Also, the Idaho Health Information Exchange typically contains all data on dispensed drugs that are paid in full or in part by a third party payer. While the IHIE might not be as robust and used as often as all would like, the Board heard testimony that it typically contains 89% of all

dispensed prescriptions. The 11% that is missing are prescriptions that were paid for by cash, not typically expensive biologic drugs. Thus, there already is a common electronic system available to communicate what was dispensed, and it has 2,500 current users.

Biologics are not tablets that might get separated from the labeled vial they are dispensed in; these are injectable drugs, whereby every syringe is clearly labeled by the manufacturer with the identity of the product.

Proponents of a notification requirement will have you believe that communication is as easy as sending an e-mail, however this is also not true, as such an electronic transmission is often not HIPPA compliant.

Although the Board heard from Idaho patients and Idaho physicians, this is certainly a national effort. First, three states passed a bill requiring notification. Then, three states passed a bill requiring notification, but establishing a sunset, because they were not sure that notification should be required. Then, MA passed a law that defined notification as an accurate record in a pharmacy computer- not much of a notification requirement. Finally, FL passed a law without a notification provision, like the rule before you. Additionally, several of the state legislatures that I mentioned earlier, states that did not have to pass a rule to allow for biosimilar substitution, have rejected attempts to pass a bill that required notification. As this process unfolds, states are establishing that they don't legislate to potential fears and unfounded possibilities.

In conclusion, this pending docket of rules is the result of intense negotiated rulemaking. Most negotiated rulemaking results in compromise...meeting in the middle on an issue. The Board has done that. The changes due to public comment from the original draft that was distributed before the August 2014 negotiated rulemaking session

to the printing of proposed language were substantial. The changes due to public comment on the printed proposed language were substantial, creating the negotiated pending language before you. The Board's vote was unanimous. The Board firmly believes that this pending rule protects public safety and avoids implementing road blocks to saving the state of Idaho and its citizens health care dollars. The Board firmly believes that pharmacists should not have to participate in a duplicative act of communication that is not required by the Federal government.

The Board has received zero opposition to the language that is contained within the rule before you. This is a good rule. The opposition is to what the rule does not contain. It will most likely be years before an interchangeable biosimilar gains FDA approval. Thus, we have years to determine if notification should be required and what such a requirement might look like. With that I urge you to pass docket 27-0101-1401, and I will stand for questions.

~~NOT TODAY~~

Docket 27.0101.1402 starts on page 43 in your pending fee rule book. In late 2013, the federal compounding quality act created a new drug outlet type: the outsourcing facility. These facilities compound drug product and distribute the product to practitioner's for in office administration. As Idaho had no such registration category, a temporary rule was promulgated. Currently about 100 outsourcing facilities are federally registered at \$15,000 per. None are located in Idaho, but they distribute into Idaho. Fees were established at the statutory maximum of \$500 for initial registration and \$250 for renewal. Registration application requirements include being federally registered, the identity of an Idaho registered or licensed pharmacist in charge, and a qualified inspection report. As most of outsourcing



Idaho Medical Association

July 28, 2014

Idaho Board of Pharmacy
1199 W. Shoreline Ln., Ste. 303
PO Box 83720
Boise, ID 83720-0067

Re: Comment on Idaho Board of Pharmacy
Rule Change Regarding Biologics and Biosimilars

The Idaho Medical Association is the preeminent statewide professional association representing approximately 2,000 Idaho physicians as well as several hundred physician assistants and nurse practitioners. We thank you for the opportunity for IMA to comment on the Board of Pharmacy's proposed rule on interchangeable biologic substitution. For our members who prescribe biologics the potential in the near future to have FDA approved, lower-cost interchangeable biosimilars available to patients is an exciting development.

It is our understanding that the FDA could approve the first biosimilar as soon as 2015. We also understand that the FDA can designate a biosimilar as "interchangeable" with an original biologic product. This is important given biologics are complex medicines made from living organisms with no two biologic medicines being exactly the same.

Because of these variations and the complexity of the conditions for which these medicines are prescribed, the IMA asks the Board of Pharmacy to incorporate the following points as you promulgate the rule on interchangeable biologic substitution:

Comment 1 – FDA Approved Interchangeable Biosimilars: We agree that the appropriate safeguard for substitution is FDA approved interchangeable biosimilars as defined in the proposed rule. As biosimilars are not exact copies, deferring to this higher level of review by the FDA is critical to ensuring physician confidence in permitting substitution of an available interchangeable biosimilar.

Comment 2 – Provide Biosimilars with the Same Safeguards as Generics: Again, it is important to note that biosimilars – even interchangeable biosimilars – are not exact copies like generic drugs. As such, the regulatory safeguards around interchangeable biosimilar substitution should be equal to, and ideally more than, the safeguards that are currently required for generic substitution. There are two important safeguards set forth

in generic substitution regulation with one allowing for prescriber autonomy and the other requiring record retention (see Idaho Administrative Code – Board of Pharmacy Section 131 – Drug Product Selection (01) and (02)). Neither of these safeguards is currently included in the proposed rule.

In order to ensure physician utilization and confidence in interchangeable biosimilars, physicians must have ultimate discretion over when a substitution can be made, as well as confidence there will be accurate documentation if a substitution occurs. If a physician believes that a brand is medically necessary then that brand shall be dispensed. Only if the physician does not specify a brand, can a biosimilar be dispensed by the pharmacist. The proposed rule should be amended to include these two important safeguards.

Comment 3 – Patient Counseling: The Board of Pharmacy already has provisions in both regulation and in statute that address patient counseling about the medicines they are taking. Under the proposed rule these patient protections would not apply to interchangeable biosimilars. The proposed rule needs to be amended to clarify that these requirements also apply to interchangeable biosimilars.

Comment 4 – Physician Communication: Due to the complexity of these products and the chronic nature of the patient population that are typically prescribed these products, it is imperative that the prescribing physician is made aware of the product dispensed once the substitution is made. There are many ways in which this information can be communicated to the physician or entered into the patient's medical record. Having this communication is a key component to any regulation governing interchangeable biosimilar substitution. This communication ensures an accurate patient record, but even more importantly, ensures we have informed patients and physicians which we know is critical to providing high quality, cost effective care.

Thank you once again for bringing this regulation forward as it is very timely. Let us know how the IMA can work more closely with you and the board as the regulation moves forward. We would appreciate the opportunity to discuss with you our comments and how best to get them incorporated into the final regulation.

Sincerely,

A handwritten signature in cursive script that reads "Susie Pouliot".

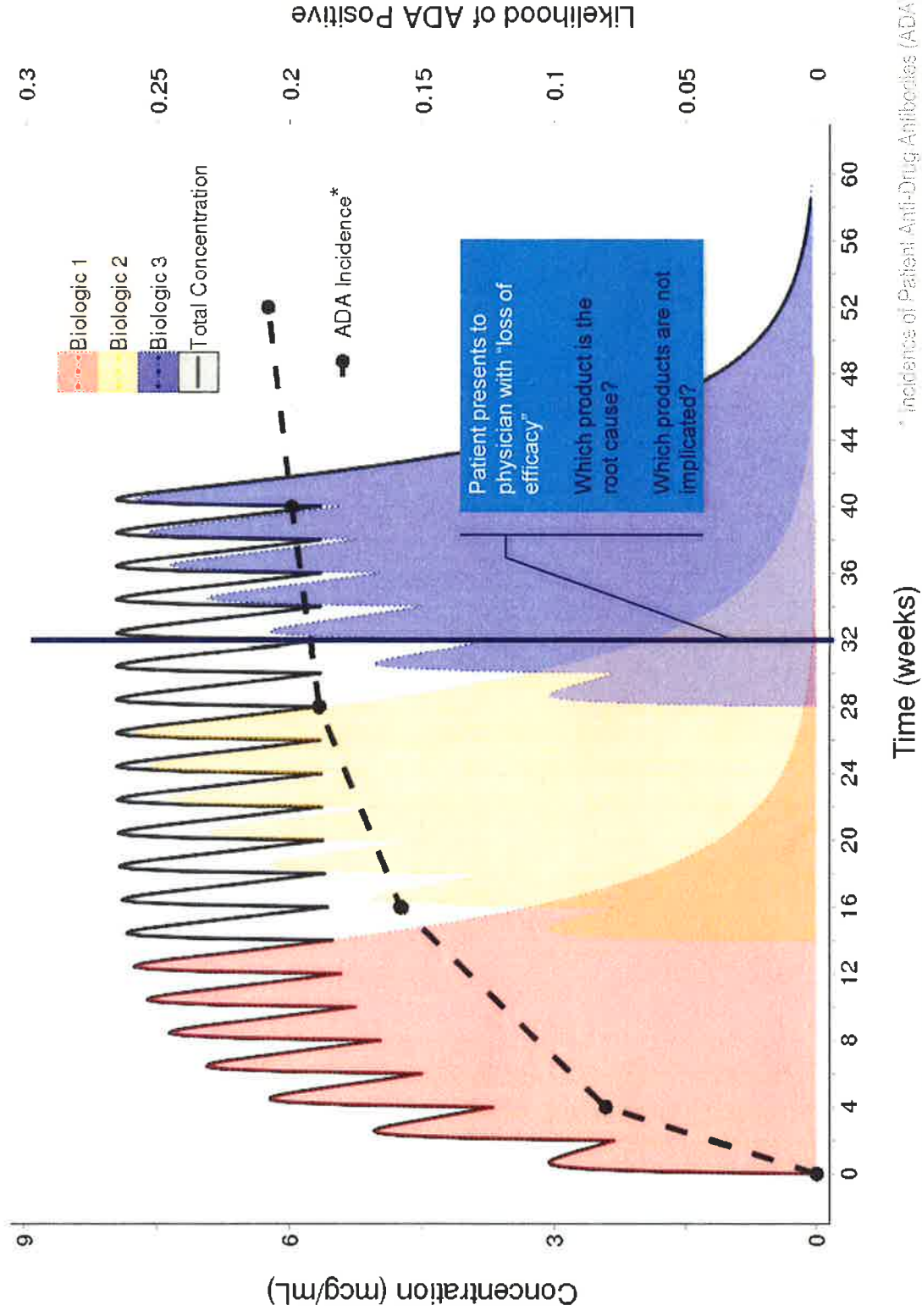
Susie Pouliot
Chief Executive Officer

**New Fall 2014 Compromise Language**

Within a reasonable time following the dispensing of a biological product, the dispensing pharmacist or the pharmacist's designee shall communicate to the prescriber the specific product provided to the patient, including the name of the product and the manufacturer. The communication shall be conveyed by making an entry in an interoperable electronic medical records system or through an electronic prescribing technology or a pharmacy record that is electronically accessible by the prescriber. If no such system is available between the pharmacist and prescriber, the pharmacist shall communicate the biologic product dispensed to the prescriber, using facsimile, telephone, electronic transmission, or other prevailing means, provided that communication shall not be required where:

- There is no FDA-approved interchangeable biologic for the product prescribed; or
- a refill prescription is not changed from the product dispensed on the prior filling of the prescription.

Biologic adverse event attribution will be difficult without complete and accurate patient records



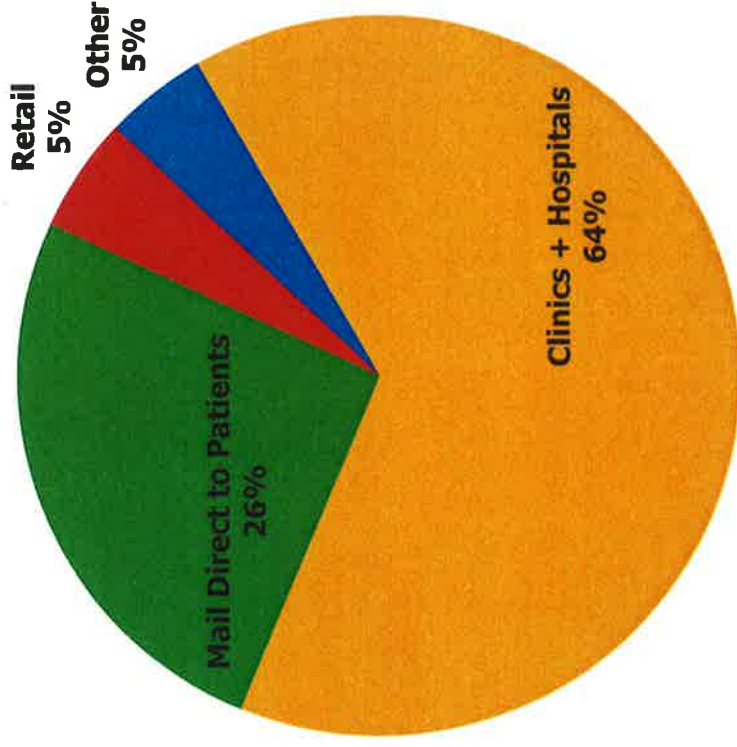
Simulation based on Bartelds, G., et al., Development of Anti-drug Antibodies Against Adalimumab and Association With Disease Activity and Treatment Failure During Long-term Follow-up. Journal of the American Medical Association 2011; 305 (14): 1460-1468
 Sources: Ben-Horin, S., et al., The decline of anti-drug antibody titres after discontinuation of anti-TNFs: implications for predicting re-induction outcome in IBD. Aliment Pharmacol Ther. 2012; 35(6): p. 714-22, and FDA Humira Clinical Pharmacology Review available at <http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/TherapeuticBiologicsApplications/ucm080610.htm>

AMGEN

27-0101-1406

2012 Distribution of Top* Biologics by Channel

Biologics by Units



- Definition of Channels**
- "Hospitals & Clinics" include non-federal hospitals and clinics.
 - "Mail Direct to Patients" includes product that flows through regular and specialty pharmacy mail service.
 - "Retail" includes chain and independent pharmacies and food stores.
 - "Other" includes federal facilities (e.g. veteran's medical facilities), HMOs, home health care, long term care, prisons, universities

* Top biologics are those constituting 1% or more of the total biologic sales. Chart represents 83.7% of total biologic sales volume by dollar

Amgen analysis based on research using IMS data of 2012 National Sales Projections.

Units of molecules representing 1% or more of sales by dollar were included. Products included: ARANESP, AVASTIN, AVONEX, AVONEX PEN, BETASERON, ENBREL, EPOGEN, ERBITUX, HERCEPTIN, HUMIRA, LUCENTIS, NEULASTA, NEUPOGEN, ORENCIA, PEGASYS, PEGASYS CONVEN PACK, PEGASYS PROCLICK, PROCIT, REBIF +, REMICADE, RITUXAN, STELARA, SYNAGIS, XGEVA, XOLAIR, YERVOY

FOR POLICY DISCUSSION PURPOSES ONLY; APPROVED FOR USE ONLY WITH GOVERNMENT OFFICIALS OR WITH THIRD PARTIES ENGAGED IN LEGISLATIVE ADVOCACY

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, January 27, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Presentation	Award Presentation by the Idaho Suicide Prevention Council for Suicide Prevention and Suicide Prevention Action Network of Idaho (SPAN) Idaho	Jeni Griffin , Executive Director, SPAN; Executive Member, Idaho Council for Suicide Prevention
Presentation	Idaho Suicide Prevention Council	Dr. Linda Hatzenbuehler Chair, The Idaho Council on Suicide Prevention
Presentation	Optum - Idaho Behavioral Health Plan Update	Colby Cameron
<u>BUREAU OF OCCUPATIONAL LICENSES</u>		
Docket No. <u>24-1001-1401</u>	Rules of the State Board of Optometry	Roger Hales Administrative Attorney
Docket No. <u>24-1501-1401</u>	Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists	Roger Hales Administrative Attorney
Docket No. <u>24-2301-1401</u>	Rules of the Speech and Hearing Services Licensure Board	Roger Hales Administrative Attorney
Docket No. <u>24-2601-1401</u>	Rules of the Idaho Board of Midwifery	Roger Hales Administrative Attorney
Docket No. <u>24-2601-1402</u>	Rules of the Idaho Board of Midwifery	Roger Hales Administrative Attorney
Docket No. <u>24-2701-1401</u>	Rules of the Idaho State Board of Massage Therapy	Roger Hales Administrative Attorney

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider	Sen Tippetts
Vice Chairman Martin	Sen Lee
Sen Lodge	Sen Schmidt
Sen Nuxoll	Sen Lacey
Sen Hagedorn	

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, January 27, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson(Lodge), Nuxoll, Hagedorn, Tippets, Lee, Schmidt, and Lacey

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** welcomed everyone to the Health and Welfare Committee (Committee). The meeting convened at 1:30 p.m.

PRESENTATION: **Jeni Griffin**, Executive Director, Suicide Prevention Action Network of Idaho (SPAN); Executive Member, Idaho Council for Suicide Prevention (ICSP). She began her presentation stating that SPAN is a suicide prevention organization. Their mission is to provide leadership in the prevention of suicide. In September at the State Suicide Prevention Conference recognition was given to individuals who had made a difference in Idaho's suicide prevention program. Senator Hagedorn was unable to attend that function so they presented his award at this Committee meeting.

Ms. Griffin stated that Senator Hagedorn has been a great advocate for suicide prevention and a supporter of the Idaho Suicide Prevention Hotline. He understands the need for more preventative efforts and the importance of support from the State. He also recognizes the importance of helping those with mental health issues who think their only option is suicide. More efforts, like Senator Hagedorn's, are needed to help fulfill the Health and Welfare Mission statement which is to promote and protect the health and safety of all Idahoans. **Ms. Griffin** then presented the award to Senator Hagedorn.

Chairman Heider asked Senator Hagedorn to make a few comments. **Senator Hagedorn** shared that one of the important reasons he became a supporter of suicide prevention is because the nation is losing 22 veterans a day to suicide. Combined with the fact that Idaho ranks at the bottom of the list in suicide prevention caused him to recognize something needed to be done. He is appreciative of what they are doing to help the citizens of Idaho. He congratulated SPAN and ICSP on their important efforts. (see attachment 1). **Chairman Heider** complimented both Senator Hagedorn and Ms. Griffin on the work SPAN is doing.

Chairman Heider turned the time to Dr. Linda Hatzenbuehler for her presentation.

PRESENTATION: Dr. Linda Hatzenbuehler, current Chair of the ICSP, began her presentation by recognizing Kathy Garrett, the founding chair of ICSP. **Dr. Hatzenbuehler** described the demographics of ICSP. It consists of a statewide group of people limited to about 20 individuals including mental health professionals, Health and Welfare employees, and survivors. Survivors include attempt survivors and family members of those who have died by suicide. The purpose of the ICSP is to oversee the implementation of the Idaho Suicide Prevention Plan (ISPP). Idaho has a great need for this type of program. The State is always one of the highest suicide rate states in the nation. In 2013, Idaho's suicide rate was 7th highest in the 50 states, and Idaho's average was 47 percent higher than the national average. Suicide is the second leading cause of death for young Idahoans ages 15 to 34, especially for males age 10-14. Also in 2013, 16 percent of Idaho youth reported seriously considering suicide, 7 percent reported having made at least 1 attempt on their own lives. **Dr. Hatzenbuehler** continued by stating there is significant economic impact related to suicide and attempted suicide. It is estimated that suicide attempts result in an annual cost of \$36 million as well as costs involved with medical care and losses in lifetime productivity. The progress made on the goals of ISPP are highlighted in the Annual Report (see attachment 2).

Chairman Heider welcomed Kim Kane who accompanied Dr. Hatzenbuehler for the presentation. **Ms. Kane** indicated that she would be talking about the Idaho Lives Project and Sources of Strength. The Idaho Lives Project is a joint partnership between the State Department of Education and SPAN of Idaho funded by a three year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The core of the program is called Sources of Strength. Research has shown young people turn to their peers first when they are contemplating suicide. In order to have youth able to help their peers, they must be trained by people who know what they are doing when dealing with suicidal youth. Schools who are part of the Idaho Lives Project have their entire staff trained. Behavioral health providers in the community must also be trained to know how to help people who need ongoing treatment. This program is bringing the leading expert in the nation on suicide assessment and management to Idaho to train personnel who are included in the Idaho Lives Project. Provisions have been made to make this training statewide. Idaho Lives Project also trains college staff and resident assistants upon request. "Shield of Care" is another best practice suicide prevention program that is designed especially for juvenile justice environments. Training is being provided for staff and some of the youth in these facilities.

Currently, they are in the 5th quarter of a 12 quarter project and have made significant progress in training professionals in several different areas. They will train 36-40 schools in the 3 year grant period. There is ongoing training in appropriate suicide prevention techniques. Sources of strength is based on the principles of hope, help and strength. Students of the program come out knowing their strengths, knowing how they can turn to trusted adults and having a sense of resiliency.

Dr. Hatzenbuehler turned the time to John Reusser, Director of the Idaho Suicide Prevention Hotline (Hotline). **Mr. Reusser** began his presentation with a brief history of the Hotline stating it had been in operation for over 2 years and 24 hour phone response was achieved on their 2 year anniversary. They currently have 47 trained volunteers. All calls are covered by them with the exception of the overnight service. Training includes 46 hours of training and shadowing before the first call is answered. There is a phone room supervised by a master's level clinician around the clock and silent phone monitoring is used on incoming calls. Volunteers are asked to commit to a four hour shift every week for one year. The Hotline has answered over 4,000 calls since launch. At least 200 of these calls have been rescue calls where the caller had already decided not to be saved and where they had already self-harmed. These calls are counted as lives saved. The Hotline has

begun training programs at various agencies where distressed callers often call such as the Tax Commission. Webcasts of the training were provided to all of the state field offices. More collaborations such as this one are being planned. The Hotline has volunteers aged 15-19 and the oldest volunteers fall into the 55-65 age bracket. One 2015 goal of the Hotline is to initiate a text response service since that is such a popular communication means for the younger, most vulnerable age group. The Ambassador Program works with SPAN and the National Alliance on Mental Illness to get the word out about the value of the Hotline (see attachment 3).

Dr. Hatzenbuehler explained that Idaho can't be satisfied with being in the top ten in suicide prevention. She suggested two goals for preventing suicide. Number one is to strive for zero suicides in the State of Idaho. Also, she suggested that Idaho needs to approve and increase affordable mental health care and decrease the stigma associated with accessing that care. She thanked the Committee for letting her present.

Chairman Heider asked if there were any questions. **Senator Tippetts** asked why Idaho ranks so high for suicide. **Kim Kane** responded that the Mountain West is high in per capita suicide. Three reasons for that are: (1) access to effective, affordable, geographically accessible mental health care., (2) culture of rugged individualism, (3) access to guns. It is well proven that there is a strong correlation between states with the highest suicide rates and a high percentage of gun owning households. If someone is at risk in a home, get the guns out of the house.

PRESENTATION: Becky diVittorio, Executive Director Optum Idaho, gave a brief overview of Optum's role in Idaho. The goal of Optum is to link people to the care they need based on nationally recognized evidence-based medical practices. This program will require change. Change is hard but it is worth the challenges it presents. She introduced Craig Herman, Senior Vice President of Optum. He oversees the work performed by Optum. She also introduced Dr. Dennis Woody, clinical director Optum Idaho. Dr. Woody's role is to lead Optum's clinical program to ensure people are getting high quality and appropriate services.

Optum was hired to advance Idaho's system of care and to take it to the next level in partnership with the State. Optum is currently serving more than 265,000 people in the Idaho Behavioral Health Plan. Evidence-based practice means the care people receive aligns with best practices established and successfully proven by the national medical and behavioral health communities. Clinical excellence will continue to enhance the reliable use of evidence based practices. Optum will offer care management training to help everyone understand their role in the system. Some steps are being taken to improve the authorization for services process, increase provider outreach meetings and add more clinical staff. The number of members accessing individual therapy in Idaho increased 36 percent, family therapy has tripled and care coordinators help 500 people each month access services.

Another important component in this program is partnering with Idahoans in their communities. People want to feel empowered to make their own decisions for their recovery and to help develop a plan to aid in that recovery. Optum partnered with the State to remove the requirements that members need to have a primary care physician referral to access behavioral health services. Optum also created a new 24/7 Member Crisis and Access Line for Medicaid members which has proved to be very beneficial. More than 8,600 members have been referred to services in their community. In addition, mental health first aid trainings resulted in more than 100 people throughout Idaho understanding how to help someone experiencing a crisis. A good example of the Mental Health First Aid program is the Speedy Foundation. It is a nonprofit organization that is dedicated to understanding mental illness, preventing suicide and fighting stigma through education, research and advocacy.

Provider collaboration is the next component in system transformation. Optum works very closely with providers to ensure that people get the care that they need in their communities. Optum reaches out to providers to provide additional support and resources so they can fully participate in the system. Optum created a tool to give providers access to additional training to keep their licenses current. Additional steps were taken to help ease the administrative burdens on providers.

Peer support is a good example of an enhancement Optum added to Medicaid. Peer support is a nationally recognized program supported by national behavioral health organizations like SAMSHA. This program has been shown to increase an individual's understanding of their own mental health or substance abuse use challenge, recovery and access to care. Peer support links a trained specialist who has managed his own behavioral health issue with someone who is facing one now (see attachments 4 and 5). **Ms. diVittorio** thanked the committee for the opportunity to present to them.

Chairman Heider asked for questions.

Senator Nuxoll indicated that she had received many negative reports about Optum. She asked if they had removed or changed a part of the program. **Ms. diVittorio** responded that they had not changed the benefits available to members except to add benefits such as peer support services and community transition support services. **Ms. diVittorio** indicated that the change she referred to is the change with evidence-based practice. Two services that they always require are prior authorization and a clinical review of the patient. These are based on looking at what the individual needs are and making sure they get those services.

Senator Hagedorn referred to various statistics of services being provided and asked if the numbers were going to increase and what the plan was to increase them. **Ms. diVittorio** stated that there were 86,000 people who called the 24/7 access line asking for support. Members do not need a referral to access services making support more accessible. Information is sent to members through a plan handbook. They are also offered outreach, staff and website support.

Senator Hagedorn said that 90 percent of members are satisfied with the provider network and 10 percent are not satisfied. He questioned how Optum plans to satisfy that 10 percent. He also asked if they have satisfaction levels available to the public. **Ms. diVittorio** responded that they do have a provider of quality program support. Audits are also taken. If a member complains, they use that information to follow up with the provider and see what is going on. They work with members through the survey process to identify things they can work on.

Senator Nuxoll asked which of the evidence based practices were excluded. **Ms. diVittorio** said the focus is helping the providers deliver the services that are known to work for an individual situation. A service wasn't necessarily excluded, but it's more looking at the individual and what is needed for their situation..

Chairman Heider thanked Becky and her team for their presentation.

**PASSED THE
GAVEL:**

Chairman Heider passed the gavel to Vice Chairman Martin.

**DOCKET NO.
24-1001-1401:**

Roger Hales, Administrative Attorney, presented **Docket No. 24-1001-1401** on behalf of the Idaho Board of Optometry (Board). He said the Board is a self-governing, self-supporting board that regulates the practice of optometry in Idaho. The rules change the reporting date for a licensee's continuing education. Effective January 1, 2017, the time frame for obtaining continuing education will change from a licensee's birth date to a calendar year (see attachment 6). **Vice Chairman Martin** asked for questions and/or testimony on this docket.

MOTION: **Senator Hagedorn** moved to approve **Docket No. 24-1001-1401**. **Senator Lacey** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 24-1501-1401: **Roger Hales** on behalf of the Board of Professional Counselors and Marriage and Family Therapists (Board), presented **Docket 24-1501-1401**. The Board is self-governing and self-supporting, and it regulates the professions of counselors and marriage and family therapists in Idaho. This rule adopts the 2014 version of the American Counseling Association Code of Ethics. This version modernizes these ethics and takes into consideration electronics. This would reflect the version of ethics currently being taught to students in counseling programs. The current code that is in effect dates back to 2005 (see attachment 7).

MOTION: **Senator Hagedorn** moved to approve **Docket No. 24-1501-1401**. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 24-2301-1401: **Roger Hales** on behalf of the Idaho Speech and Hearing Services Board (Board) presented **Docket No. 24-2301-1401**. Board is a self-governing, self-supporting board that regulates the practice of audiology, speech language pathology, and hearing aid dealers and fitters in Idaho. Last year the Legislature passed HB 357, which amended the definition of a quorum. The law change provides that a quorum can be established if at least one member of the relevant profession is present when taking action that affects the profession, its applicants, or licensees. Proposed rules are being revised to comply with the new law change (see attachment 8).

MOTION: **Senator Nuxoll** moved to approve **Docket No. 24-2301-1401**. **Senator Heider** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 24-2601-1401: **Roger Hales** on behalf of the Idaho Board of Midwifery, presented **Docket No. 24-2601-1401**. These rules are brought by the Idaho Board of Midwifery. These proposed rules make changes based upon a law passed last year, HB 438. These proposed rules track the law change that was passed last year. Rules were reviewed by interested individuals and there have been no objections (see attachment 9).

Senator Tippetts had a language question referring to the transfer or termination of care by a midwife who deems it necessary to transfer or terminate care pursuant to the laws and rules of the board. He has concern that carte blanche is being given to a midwife to transfer or terminate care for any reason. He assumes there are reasons someone could inappropriately terminate care. **Mr. Hales** stated that the language is verbatim from the law that passed last year. He indicated that there are times when the patient may not follow the midwife's directions so there may be a good reason to terminate that care. **Paula Wieens**, a member of the Idaho Board of Midwifery, said that there are cases that can be identified that don't necessarily need to go on a list, where the provider would transfer the care. A client may not be paying for her services or showing some sort of warning that she would not be an appropriate candidate for midwifery care. The midwife may choose to transfer her care to a more appropriate form of care. Midwives tend to develop close relationships with clients. There are instances when the midwife has decided to terminate the care of a client and to transfer her to the care of a physician. The client has chosen not to seek the same care. This leaves the midwife in a tenuous situation. If the midwife has done all she can to make the transfer, is there any responsibility on the part of the midwife? **Senator Tippetts** said there are reasons why they should make the transfer. He verified that the language was in last year's bill. **Vice Chairman Martin** said he had similar concerns last year, but felt comfortable in passing the bill. **Senator Nuxoll** commented that it is not the problem of transferring, it's the problem of not transferring. The problem is usually that the doctors are unhappy that they are not transferring (see attachment 9). **Vice Chairman Martin** asked for any other questions or comments from the audience.

- MOTION:** **Senator Nuxoll** moved to approve **Docket No. 24-2601-1401**. **Senator Lee** seconded the motion. Motion carried by **voice vote**.
- DOCKET NO. 24-2601-1402:** **Roger Hales**, on behalf of the Idaho Board of Midwifery, **Docket No. 24-2601-1402**. These rules are also presented by the Idaho Board of Midwifery. Rules relate to conditions when a midwife must facilitate the immediate transfer of a newborn to a hospital. They also relate to conditions when midwives must consult with a pediatric provider. On page 224 the conditions are listed and have been vetted and approved by the medical association and the board. Also on page 224 the conditions are listed when a midwife must consult a pediatric provider (see attachment 10).
- MOTION:** **Senator Hagedorn** moved to approve **Docket No. 24-2601-1402**. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**.
- DOCKET NO. 24-2701-1401** **Roger Hales**, on behalf of the Idaho Board of Massage Therapy (Board), presented **Docket No. 24-2701-1401**. These rules clarify a continuing education course and also clarify supervision. The rule deletes approved courses that involve light therapy. Where they are prohibited from performing light therapy, the Board felt it inappropriate to give continuing education credit for courses dealing with such therapy and continue with continuing education in areas that they could practice. On page 227 the Board has clarified "supervision". There have been questions about different types of supervision. Clinical work by a student requires direct on-site supervision. Field work requires that the supervisor be available, but not on-site (see attachment 11). **Senator Hagedorn** asked what the definition of light is. **Mr. Hales** stated that it was clear under the Massage Therapy Act that they are prohibited from practicing light therapies. It may extend to infra-red light, but he wasn't sure.
- Linda Chatburn**, Massage Therapy Board member, said that the umbrella term is light, but that it includes infrared light, red light, and blue laser light. They are effective methods but do not fall under the terms of massage therapy.
- MOTION:** **Senator Lee** moved to approve **Docket No. 24-2701-1401**. **Senator Tippets** seconded the motion. The motion carried by **voice vote**.
- PASSED THE GAVEL:** Vice Chairman Martin passed the gavel back to Chairman Heider. **Chairman Heider** thanked everyone for participating and for their input.
- ADJOURNED:** There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:27 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Assistant Secretary

Talking Points
Docket No. 24-2301-1401

Idaho Speech and Hearing Services Board

- These rules are brought by the Idaho Speech and Hearing Services Board. The Board is a self-governing, self-supporting board that regulates the practice of audiology, speech language pathology, and hearing aid dealers and fitters in Idaho.
- The Board is served by the Idaho Bureau of Occupational Licenses.
- Last year the Legislature passed House Bill 357, which amended the definition of a quorum of the Board. The law change provides that a quorum can be established if at least one member of the relevant profession is present when taking action that affects the profession, its applicants, or licensees.
- These proposed rules are being revised to comply with the new law change.
- These rules were discussed at an open and noticed meeting of the Board.
- There has been no opposition to these rules.

Talking Points
Docket No. 24-2601-1401

Idaho Board of Midwifery

- The rules are brought by the Idaho Board of Midwifery.
- The Board is a self-governing, self-supporting board that regulates the practice of midwives in the state of Idaho.
- The Board is served by the Idaho Bureau of Occupational Licenses.
- These proposed rules make changes based upon a law passed last year, Bill 438.
- Review the rules.
 - The rules were reviewed by the Idaho Medical Association and the Idaho Midwifery Council; there have been no objections or concerns.

Docket No. 24-2601-1402

- These rules are also presented by the Idaho Board of Midwifery. The rules were prepared by a consensus of the Idaho Midwifery Council, the Idaho Medical Association, and the Board.
- These rules relate to conditions when a midwife must facilitate the immediate transfer of a newborn to a hospital. They also relate to conditions when midwives must consult with a pediatric provider.
- Review rules.
- These rules were discussed at an open noticed meeting of the Board.
- There has been no opposition to these rules.



Suicide in Idaho: Fact Sheet January 2015

- Suicide is the 2nd leading cause of death for Idahoans age 15-34 and for males age 10-14. (The leading cause of death is accidents.)
- Idaho is consistently among the states with the highest suicide rates. **In 2013 Idaho had the 7th highest suicide rate, 47% higher than the national average.**
- In 2013, 308 people completed suicide in Idaho; a slight increase from 2012.
- Between 2009 and 2013, 79% of Idaho suicides were by men.
- In 2013, 65% of Idaho suicides involved a firearm. The national average is 51%.
- 15.8% (1 in 7) of Idaho youth attending regular public and charter high schools reported seriously considering suicide in 2013. 7.0% (1 in 14) reported making at least one attempt.
- Between 2009 and 2013, 85 Idaho school children (age 18 and under) died by suicide. Fifteen of these were age 14 and under.
- It is estimated that suicide attempts in Idaho result in \$36 million in costs annually. Idaho's costs for suicide completions annually is over \$850,000 in medical care alone, and \$343 million in total lifetime productivity lost.
- In 2012, there were 40,600 deaths by suicide in the United States, an average of 1 person every 13 minutes.

Idaho Resident Suicides by Region – 2013

Region	Anchor City	Suicides	Rate (per 100,000)	Population	Tot. # suicides 2009-2013	5-yr Avg Rate
1	Coeur d'Alene	41	18.8-	217,551	234	21.8
2	Lewiston	18	16.9-	106,588	105	19.8
3	Nampa	56	21.3*	263,411	228	17.8
4	Boise	77	16.8-	459,035	353	15.9
5	Twin Falls	41	21.7*	188,860	195	21.0
6	Pocatello	44	26.1*	166,138	175	21.1
7	Idaho Falls	31	14.7-	210,553	198	19.1

* increase from 2012, - decrease from 2012

Idaho Suicides by Age/Gender 2009-13 Over 5 year period

Age	Total	Male	Rate	Female	Rate
< 15	15	12	4.0	3	1.1
15-24	219	172	29.8	47	8.5
25-34	202	168	31.3	34	6.6
35-44	262	193	39.4	69	14.5
45-54	321	244	47.9	77	15.0
55-64	243	184	40.0	59	12.6
65-74	119	103	36.1	16	5.4
75-84	68	63	44.8	5	3.0
85+	39	34	72.3	5	6.0

Method 2009-13 (all ages)

Firearm	64.95%
Poisoning	17.5%
Suffocation	12.3%
Cut/Pierce	.7%
Fall	1.3 %
Other	3.2%

Idaho Suicide Rates 2001 – 2013

Year	Number	ID Rate	US Rate
2001	213	16.1	10.8
2002	203	15.1	11.0
2003	218	16.0	10.9
2004	239	17.2	11.1
2005	225	15.7	11.8
2006	218	14.9	11.2
2007	220	14.7	11.5
2008	251	16.7	11.9
2009	307	19.9	12.0
2010	209	18.5	12.4
2011	284	17.9	12.7
2012	299	18.7	12.9
2013	308	19.1	13.0

Moving Toward Zero Suicides In Idaho



Report to Governor C.L. "Butch" Otter
December 2014

Idaho Council on Suicide Prevention
Linda Hatzenbuehler, Chair

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IDAHO COUNCIL ON SUICIDE PREVENTION 2014 REPORT TO THE GOVERNOR

Executive Summary

As indicated in the original Executive Order, established by Governor Otter in 2010, the purpose of the Idaho Council on Suicide Prevention (ICSP) is to:

- A. Oversee the implementation of the Idaho Suicide Prevention Plan;
- B. Ensure the continued relevance of the Plan by evaluating implementation and developing changes and new priorities to update the Plan;
- C. Be a proponent for suicide prevention in Idaho; and
- D. Prepare an annual report on Plan Implementation for the Governor and Legislature.

The ICSP was developed because death by suicide remains a significant public health concern in Idaho as indicated by the following statistics:

1. Idaho consistently ranks among the top 10 states in the country with the highest number of completed suicides per capita. In 2013, 308 people completed suicide in Idaho, an increase from 2012. ⁱ
2. In the five years from 2009 through 2013, 85 youth age 18 and younger and 134 youth age 19 – 24 died by suicide in Idaho. The Idaho Youth Risk Behavior Survey consistently shows that 1 out of 7 Idaho high school students report seriously considering suicide, 1 out of 8 has a suicide plan and 1 out of 14 has attempted suicide. ⁱⁱ
3. The annual cost of suicide attempts in Idaho is estimated at \$36 million. The annual financial burden of completed suicides in Idaho is estimated at over \$850,000 in medical care alone and \$343 million in total lifetime productivity lost. ⁱⁱⁱ

This annual report documents and summarizes the events that have occurred during the past year addressing the implementation of strategies by partner agencies and groups addressing the goals of the 2011 Idaho Suicide Prevention Plan. The executive summary also documents some of the activities completed by the Council itself. Full reports of partner groups follow the Executive Summary.

The 2014 calendar year witnessed several very significant changes and accomplishments by the ICSP itself. The ICSP sponsored training by the Western Interstate Commission for Higher Education (WICHE) on implementing suicide prevention strategies into primary care. Physician and provider at St. Lukes Hospital participated in the event. In May, the founding chair of the Council, Kathie Garrett, stepped down, and Dr. Linda Hatzenbuehler, a long-time member of the Idaho Planning Council on Mental Health, was appointed Chair. In addition to a new chair, several other members of the Council completed their three-year terms or left the Council for other reasons, and new members were recruited and officially appointed in August. A current membership list is attached to this report. In August, a new Executive Order was issued establishing the Council, as the original Executive Order had expired. The new Executive Order included a minor change concerning regional representation of members. During the annual meeting, the strategic plan developed in 2011 was reviewed. In particular, the goals in the 2011 plan were reviewed, and it was the consensus of all present that the 2011 goals, as established,

GOAL 3: GATEKEEPER EDUCATION

The education of professionals and others working with people at risk for suicide include effective suicide prevention curricula and ongoing gatekeeper and other suicide prevention training.

- The Idaho State Prevention and Support Conference, hosted by the State Department of Education (SDE), featured Dr. Scott Polland, premier expert on school violence, crisis and suicide prevention. Participants included school counselors, teachers, administrators, resource officers and community stakeholders.
- The Idaho Lives Project awareness directly to over 7,700 individuals and indirectly to over 133,000 through radio and other promotional materials.
- The VAMC presented on suicide prevention and intervention at the National Chaplain's Conference, in Twin Falls, Idaho, June 2014.
- The Idaho Basic Juvenile Probation Officer Academy has enhanced their curriculum in suicide prevention.
- The National Alliance on Mental Illness (NAMI) Idaho held "Question, Persuade, Refer" (QPR) training during their annual conference in Coeur d'Alene. Twenty-five individuals were trained on warning signs and referral techniques for use in their communities.

GOAL 4: BEHAVIORAL HEALTH PROFESSIONAL READINESS

Mental health and substance abuse treatment professionals are trained to use current, appropriate, and recommended practices for assessing and treating individuals who show signs of suicide risk.

- The Western Interstate Commission for Higher Education (WICHE) provided training for primary care health professionals in suicide prevention activities at St. Luke's Hospital
- SPAN Idaho Region 6 and the Idaho Lives Project provided expert clinical suicide assessment and management training by Dr. M. David Rudd to 535 behavioral health providers statewide.
- SPAN Idaho brought Dr. Thomas Joiner, one of the world's leading experts in suicide prevention, to a conference attended by mental health professionals, clergy, school personnel, survivors, law enforcement and community leaders.
- The Department of Health and Welfare Division of Behavioral Health through its Quality Assurance unit has implemented new requirements for risk assessment training.

GOAL 5: COMMUNITY INVOLVEMENT

Community leaders and stakeholders develop and implement suicide prevention activities that are current, recommended and culturally appropriate that are specific to their regions and communities.

- The SDE provided a "Safe Schools in Idaho" seminar for law enforcement and school officials which covered general principles of threat assessment in schools.
- SPAN Idaho developed a SPAN chapter at Fort Hall.

lead Idaho state government agency that is responsible for Idaho's suicide prevention and intervention efforts.

- The Idaho Council on Suicide Prevention (ICSP) participated in a presentation to the Health Quality Planning Commission (HQPC) and a roundtable, sponsored through St. Alphonsus Regional Medical Center, which will lead to a proposal for a concurrent resolution addressing suicide prevention system of care implementation in Idaho.

GOAL 10: DATA

Data are available on which to make decisions regarding suicide prevention services.

- The SDE, Office of Drug Policy and Department of Health & Welfare developed the 2014 Idaho Youth Prevention Survey (IYPS), which gleaned valuable information about students at risk for suicide and other unhealthy behaviors.
- The Idaho Lives Project collected and reported quantitative and qualitative data relating to its seven project goals including those related to 97 trainings of over 2,900 individuals.
- Regional Mental Health Programs, Optum Idaho and BPA report deaths by suicide of clients who received a service.
- In August 2014, the Idaho Department of Health and Welfare, Bureau of Vital Records and Health Statistics published the Idaho Vital Statistics Suicide Report with data focused on the five-year period of 2009-2013. The report can be found at: <http://www.healthandwelfare.idaho.gov/Portals/0/Users/074/54/1354/Suicide%20Report%202013.pdf>

In summary, 2014 witnessed multiple successful grassroots efforts to address the incidence of deaths by suicide in Idaho. Much work needs to be done to implement more comprehensive strategies to address this significant public health issue. Policies need to be in place which promote evidence-based suicide prevention efforts aimed at multiple sectors of our communities: schools, law enforcement, health and mental health providers and systems, and the media. The ICSP pledges to work diligently to decrease the number of our citizens who die by suicide.

Respectfully submitted,



Linda C. Hatzenbuehler, Ph.D., ABPP
Chair

ⁱ Idaho Bureau of Vital Records and Health Statistics

ⁱⁱ State Department of Education, YRBS, 2013

ⁱⁱⁱ Kirkwood, A. Idaho Suicide Prevention Hotline Report, Institute of Rural Health, Idaho State University, 2010

Idaho Council on Suicide Prevention

2014 Council Members

Krissy Broncho
Native American
Fort Hall, ID

Pam Catt-Oliason
Commission on Aging
Boise, ID

Dieuwke Dizney-Spencer
Department of Health and Welfare
Boise, ID

Kathie Garrett
NAMI Idaho
Meridian, ID

Jeni Griffin
SPAN Idaho
Idaho Falls, ID

Linda Hatzenbuehler, Chair
Idaho State University
Pocatello, ID

Karen Hostetter
Department of Education
Boise, ID

Kim Kane
Idaho Lives Project
Boise, ID

Heidi Lasser
Department of Health and Welfare
Boise, ID

Matt Olsen
Bannock County Juvenile Justice
Pocatello, ID

Catherine M. Perusse
NAMI Board
Sandpoint, ID

Linda Peterson
Survivor
Boise, ID

Mary Pierce
Boise Veterans Affairs
Midvale, ID

John Reusser
Idaho Suicide Prevention Hotline
Boise, ID

Neva Santos
Idaho Academy of Family Physicians
Boise, ID

Laura Senderowicz
Ada County Sheriff's Office
Boise, ID

Amanda Wester
Youth Representative
Boise, ID

Stewart Wilder
Survivor
Boise, ID

John Goedde
State Senator
Coeur d'Alene, ID



Executive Department
State of Idaho

The Office of the Governor
EXECUTIVE DEPARTMENT
STATE OF IDAHO
BOISE

State Capitol
Boise

EXECUTIVE ORDER NO. 2014-08

**ESTABLISHING THE IDAHO COUNCIL ON SUICIDE PREVENTION
REPEALING AND REPLACING EXECUTIVE ORDER NO. 2010-12**

WHEREAS, Idaho's suicide rate is consistently higher than that of the United States as a whole; and

WHEREAS, in 2013, suicide was the second leading cause of death for Idahoans aged 10-34 and for males aged 10-34 and for females aged 15-24; and

WHEREAS, in 2013, 308 people completed suicide in Idaho, a 3-percent increase over 2012, and an 8.5-percent increase over 2011; and

WHEREAS, suicide is particularly devastating, especially in the rural areas of Idaho;

NOW, THEREFORE, I, C.L. "BUTCH" OTTER, Governor of the State of Idaho, by virtue of the powers and authority vested in me by the Constitution and laws of this state, do hereby establish the Idaho Council on Suicide Prevention.

I. The Council's responsibilities shall be:

- A. To oversee the implementation of the Idaho Suicide Prevention Plan;*
- B. To ensure the continued relevance of the Plan by evaluating implementation and developing changes and new priorities to update the Plan;*
- C. To be a proponent for suicide prevention in Idaho; and*
- D. To prepare an annual report on Plan Implementation for the Governor and Legislature.*

II. The Governor shall appoint all members of the Council with state regional representation in mind. The Council shall include representatives from:

- A. The Office of the Governor;*
- B. The Idaho State Legislature;*
- C. The Department of Health and Welfare;*
- D. The Department of Education or School Districts;*
- E. Juvenile justice;*
- F. Adult corrections;*
- G. SPAN Idaho;*
- H. The mental health profession;*
- I. The National Alliance for the Mentally Ill or another mental health advocacy group;*
- J. Suicide bereavement and attempt survivors;*
- K. An Idaho tribe;*
- L. Idaho youth;*
- M. The Commission on Aging or Aging Services;*
- N. The military, a veteran or the Division of Veterans Services;*
- O. Organizations engaged in suicide prevention and awareness activities; and*
- P. Various regions of Idaho.*



Suicide in Idaho: Fact Sheet October 2014

- Suicide is the 2nd leading cause of death for Idahoans age 15-34 and for males age 10-14. (The leading cause of death is accidents.)
- Idaho is consistently among the states with the highest suicide rates. **In 2012 (the most recent year available) Idaho had the 8th highest suicide rate, 44% higher than the national average.**
- In 2013, 308 people completed suicide in Idaho; a slight increase from 2012.
- Between 2009 and 2013, 79% of Idaho suicides were by men.
- In 2013, 65% of Idaho suicides involved a firearm. The national average is 51%.
- 15.8% (1 in 7) of Idaho youth attending regular public and charter high schools reported seriously considering suicide in 2013. 7.0% (1 in 14) reported making at least one attempt.
- Between 2009 and 2013, 85 Idaho school children (age 18 and under) died by suicide. Fifteen of these were age 14 and under.
- It is estimated that suicide attempts in Idaho result in \$36 million in costs annually. Idaho's costs for suicide completions annually is over \$850,000 in medical care alone, and \$343 million in total lifetime productivity lost.
- In 2012, there were 40,600 deaths by suicide in the United States, an average of 1 person every 13 minutes.

Idaho Resident Suicides by Region – 2013

Region	Anchor City	Suicides	Rate (per 100,000)	Population	Tot. # suicides	
					2009-2013	5-yr Avg Rate
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2	Lewiston	18	16.9-	106,588	105	19.8
3	Nampa	56	21.3*	263,411	228	17.8
4	Boise	77	16.8-	459,035	353	15.9
5	Twin Falls	41	21.7*	188,860	195	21.0
6	Pocatello	44	26.1*	166,138	175	21.1
7	Idaho Falls	31	14.7-	210,553	198	19.1

* increase from 2012, - decrease from 2012

Idaho Suicides by Age/Gender 2009-13 Over 5 year period

Age	Total	Male	Rate	Female	Rate
< 15	15	12	4.0	3	1.1
15-24	219	172	29.8	47	8.5
25-34	202	168	31.3	34	6.6
35-44	262	193	39.4	69	14.5
45-54	321	244	47.9	77	15.0
55-64	243	184	40.0	59	12.6
65-74	119	103	36.1	16	5.4
75-84	68	63	44.8	5	3.0
85+	39	34	72.3	5	6.0

Method 2009-13 (all ages)

Firearm	64.95%
Poisoning	17.5%
Suffocation	12.3%
Cut/Pierce	.7%
Fall	1.3 %
Other	3.2%

Idaho Suicide Rates 2001 – 2013

Year	Number	ID Rate	US Rate
2001	213	16.1	10.8
2002	203	15.1	11.0
2003	218	16.0	10.9
2004	239	17.2	11.1
2005	225	15.7	11.8
2006	218	14.9	11.2
2007	220	14.7	11.5
2008	251	16.7	11.9
2009	307	19.9	12.0
2010	209	18.5	12.4
2011	284	17.9	12.7
2012	299	18.7	12.9
2013	308	19.1	n/a

Partner Reports
Accomplishments in Suicide Prevention



United States Department of Veterans Affairs

Boise Veterans Affairs Medical Center

Suicide Prevention Program

The Veterans Affairs' basic strategy for suicide prevention is to provide ready access to high quality mental health (and other health care) services supplemented by programs designed to help individuals and families engage in care and to address suicide prevention in high risk patients. Outreach, education and participation on community boards are also critical aspects of the Boise VAMC suicide prevention program.

- The Suicide Prevention Coordinator ensures suicidal Veterans receive the appropriate services. In the last 12 months 217 Idaho Veterans were connected to the Suicide Prevention Coordinator by Veterans Crisis Line consults, community hospitals, various social welfare agencies, families and friends, and have been connected with VA Services.
- Screening and assessment processes have been set up throughout the system to assist in the identification of Veterans at risk for suicide. A chart "flagging" system has been developed to assure continuity of care and provide awareness among providers. Veterans who have been identified as being at high risk receive an enhanced level of care, including missed appointment follow-ups, safety planning, weekly follow-up visits and care plans that directly address their suicidality. In the last 12 months 84 Idaho Veterans have been identified as High Risk for Suicide with one High Risk Veteran suicide.
- The Suicide Prevention Coordinator and VA Mental Health staff provide community outreach that includes education on veterans mental health issues, suicide prevention

The Idaho Lives Project is a joint project of the State Department of Education and the Suicide Prevention Action Network of Idaho. The Project is federally funded by the Garrett Lee Smith State and Tribal Youth Suicide Prevention Grant awarded through the Substance Abuse and Mental Health Services Administration on October 7, 2013. The mission of this three-year Project is to foster connectedness and resilience throughout Idaho school communities to prevent youth suicide.

The Idaho Lives Project's four overlapping programs create a comprehensive approach to youth suicide prevention in Idaho.

The **School Communities Program** brings *Sources of Strength*, an ongoing, comprehensive wellness program, and the most well-researched program of its kind, into Idaho middle/junior high and high schools to build connectedness and resilience among the students, and increase referrals and treatment of students at risk for suicide. Because students in crisis must have trained, trusted adults to turn to, the program also trains school staff and communities to identify, assist and refer those at risk.

In 2014, the Project provided *Sources of Strength* training to 14 schools statewide, including booster (second) trainings to 8 of those schools. Schools included Priest River Lamanna High School, Lapwai Middle/High School, Parma Middle School, Parma High School, Homedale High School, Nampa High School, Emmett High School, Frank Church High School (Boise), Silver Creek High School (Hailey), Pocatello High School, Preston Jr. High School, Preston High School, Salmon Middle/High School, and Teton High School (Driggs). Over 500 middle and high school students, and 70 school adult advisors were trained through this program. School staff members and community members also received training in suicide prevention. The Project trained 800 school staff and 154 community members in 2014. The majority (over 80%) of school staff participants and 85% of community members rated the training and its value to them as outstanding or above average.

Qualitative data from the *Sources of Strength* trainings have been overwhelmingly positive with several examples of students utilizing skills learned in trainings, positive changes in student behavior and students identified for risk of suicide.

The **Health Professionals Program** is based on the knowledge that trained adults must be able to refer youth and their parents to well-trained health professionals. This program brings expert, evidence-based suicide assessment and management training to behavioral health and primary care professionals throughout Idaho.

The Idaho State Department of Education: Alignment to Suicide Prevention Goals

The Idaho State Prevention & Support Conference is hosted annually by the Idaho State Department of Education (SDE). The conference is a gathering focused on innovation, best practices, collective problem-solving and motivation to most effectively address youth risk behaviors, foster optimal health and realize academic success for Idaho students. The most recent conference was held in April, 2014, with workshops offering topics related to school safety planning, emergency operations, suicide prevention, law enforcement / school partnerships, drug and alcohol prevention, violence prevention, out of school programming and community engagement in schools. Participants included approximately 425 school counselors, teachers, administrators, school resource officers and community stakeholders.

A central focus for the 2014 conference was school safety, featuring a keynote address by Dr. Scott Poland, a premier expert on school violence, crisis response and suicide prevention. Research has emphasized the need for all students to feel a connection to their school and it is very important for each student to have a significant relationship with one or more adults at their school. Numerous school tragedies could have been prevented if students had come forward and alerted school officials and other adults about the warning signs of suicide and/or violence. The prevalence of bullying, school violence, and suicide requires that schools improve prevention efforts and Dr. Poland's keynote address specifically addressed how to help schools and communities develop and enhance their knowledge and understanding of serious risk factors for students and how to respond for the prevention of suicidal and violent behavior. Participants also learned effective strategies to improve mental health services for students and how to increase student involvement in school safety. The conference also hosted a break-out workshop about the importance of belongingness in school-wide suicide prevention, presented by a staff member from the Suicide Prevention Action Network of Idaho. These activities aligned closely with goals three and five of the Idaho Suicide Prevention Plan by educating the community and school professionals about appropriate suicide prevention activities and awareness.

During the 2014 legislative session, the Idaho legislature appropriated \$2,165,700.00 in funding to partially restore Safe and Drug Free schools money (HB 640). The dedication of these funds for substance abuse prevention and school safety improvements came about through the work of a safe and secure task force convened by the SDE. The SDE has been dispersing this funding to school districts for the provision of school safety improvements and/or prevention activities. In their applications for funding, many school districts identified suicide prevention as a district priority. In alignment and encouragement of the third goal in the Idaho Suicide Prevention Plan, the SDE has provided technical assistance and support for school districts regarding best practice programs about suicide prevention/response and additional school safety resources.

The tenth goal of the Idaho Suicide Prevention Plan focuses on the availability of data to make decisions regarding local and statewide prevention services. In collaboration with the Idaho Office of Drug Policy and the Idaho Department of Health and Welfare, the SDE assisted in the

Idaho Council for Suicide Prevention

Division of Behavioral Health Report 2014:

Idaho's First Community Crisis Center

Idaho Legislature appropriated \$1.52 million in ongoing State general funds and \$600,000 in one-time federal money in the 2014 session for the Division of Behavioral Health to open and run one behavioral health crisis center in Idaho. Idahoans experiencing a behavioral health crisis often are incarcerated, hospitalized or treated in hospital emergency departments because an appropriate level of care to meet their needs is unavailable. The crisis center will be a place to go voluntarily and where people in crisis will be able to access services they need, get stabilized and leave with a treatment plan.

On June 26, 2014, Gov. C.L. "Butch" Otter announced Idaho Falls as the site for the behavioral health crisis center. Bonneville County graciously agreed to be the recipient of the contract with the state. They were able to quickly identify a building to buy for the crisis center. The crisis center is located on Anderson Street in Idaho Falls. Many community partners worked closely with Bonneville County to get the crisis center up and running. These partners included: Bonneville County Sheriff's Office, Idaho Falls Police Department, Eastern Idaho Regional Medical Center, the Department of Health and Welfare (DHW), Targhee Regional Public Transportation Authority, National Alliance on Mental Illness, Crisis Intervention Teams, public behavioral health providers and other interested community members. This team helped create a logo and brochure for the crisis center, as well as establishing a bus stop at the crisis center. The community has offered a lot of in-kind and financial donations, including an industrial washer and dryer. Bonneville County looked for and successfully hired a coordinator for the crisis center. The communities of eastern Idaho are excited to have this resource to help those in a behavioral health crisis to receive the help they need. The center will be accessible to all residents on a voluntary basis. The crisis center has been modeled on the best practices of other states where similar crisis centers have succeeded, and will follow Idaho Administrative Rule 16.07.30. It will operate around the clock, every day of the year and it is available to provide evaluation, intervention and referral for people experiencing a crisis because of serious mental illness or substance use disorder. The Behavioral Health Crisis Intervention Center of Eastern Idaho officially opened its doors on December 12, 2014. The ribbon cutting ceremony occurred on Monday, December 15, 2014. "We're grateful for the funding we received. We anticipate the information gathered from the center will demonstrate the effectiveness of the model and lead to the development of additional crisis centers in the state." said Ross Edmunds, administrator for the Division of Behavioral Health at the Idaho Department of Health and Welfare.

facilitated by Connecticut Community for Addiction Recovery (CCAR). Recovery Idaho will encompass recovery from both substance use and mental health disorders. In addition, CCAR also facilitated training for recovery coaches, bringing Idaho's total number of recovery coach trainers to 25. In addition, the division sponsored Idaho's first recovery coach training with grant funding in May 2013. Since then, more than 200 recovery coaches have been trained, with coaches now located in every region of the state. Recovery Coaches act as personal guides and mentors for individuals that are working toward recovery from alcohol and substance use. Coaches help others overcome personal and environmental obstacles to recovery, and link them to community sources of support.

QA Practices to Support Suicide Prevention

The Idaho Department of Health and Welfare Division of Behavioral Health (DBH) supports the goal to reduce or eliminate deaths by suicide within the State of Idaho. The DBH has a deep commitment to safety in behavioral healthcare and has initiated continuous quality improvement efforts to achieve that goal.

To support the goals of DBH the Quality Assurance unit (QA) has implemented several practices to assist with the achievement of this goal. These practices include the following systematic steps to enhance the safety culture:

- Regional Mental Health Programs, Optum Idaho and BPA report deaths by suicide of clients who received a service.
- Central Office QA tracks all suicides reported and reports results annually to the DBH Administrator.
- QA conducts a review of suicides
- QA requests that Root Cause Analysis (RCA) be completed by Regional Mental Health Programs for deaths within 30 days of service.
- QA recommends action plans as a result of RCA
- Changes to the existing policy regarding risk assessments
- New requirements related to risk assessment training



1-800-273-TALK (8255)

A Program of Mountain States Group
Accomplishments and Activities 2014

The Idaho Suicide Prevention Hotline is committed to the prevention of suicide in Idaho. The Hotline is a program of Mountain States Group, a 501 (c) (3) non-profit organization. The Hotline provides crisis intervention, emotional support, resource referrals, and follow-up calls if needed to all Idahoans who are suicidal or in crisis. ISPH nears its third full year of operations, earning national accreditation with Contact USA, securing additional one-time United Way funding, training its 7th volunteer class, and is on schedule to achieve 24/7 phone response by late November 2014.

Idaho Suicide Prevention Hotline Call Statistics January 1 to September 30, 2014		
	3rd Quarter	Year to Date
Total Calls Received	734	1867
Military Members / Families	140	468
Rescue Calls (approximate)	30	100
Caller Age:		
10 - 14	26	76
15 - 19	87	215
20 - 24	53	155
25 - 34	85	195
35 - 44	37	111
45 - 54	70	185
55 - 64	123	383
65 - 74	21	62
75 - 84	10	16
85+	0	5
Didn't Report	222	464
Total Calls Received	734	1867

*1st Quarter amount corrected from previous report

Volunteer and Staff Recruitment and Training

In 2014 ISPH trained approximately 40 prospective volunteers in the ASIST (applied suicide intervention skills training) model. Approximately 50 volunteers are currently active as hotline Phone responders. In the first 3 quarters of 2014 volunteers contributed a total of 7660 hours, valued at \$145,690). To operate 24 hours per day/7 days per week with a minimum of 2 volunteer responders per shift, ISPH will need approximately 80 volunteer Phone Responders. All shifts require onsite supervision by a master's level clinician or equivalent. Initial overnight phone coverage will be provided by a paid supervisory staff person as we continue to train more responders and address the challenge of providing more robust overnight staffing. We have begun recruiting a separate cohort of non-phone worker volunteers or 'Hotline Ambassadors' to assist with community outreach and support tasks both in Boise and across the state and have provided quality display materials to our SPAN partners in the Coeur d'alene and Idaho

Matt Olsen

Director

Bannock County Juvenile Justice

The Idaho Basic Juvenile Probation Officer POST Academy has enhanced the curriculum in suicide prevention by increasing curriculum focus on recognizing the signs and symptoms of suicidal risk, as well as effective ways to respond when it is determined that risk exists. The new curriculum will be implemented in the next Juvenile Probation Officer POST Academy in December of 2014.

The SHOSHONE-BANNOCK TRIBES



COUNSELING & FAMILY SERVICES

P. O. BOX 306
FORT HALL, IDAHO 83203
PHONE (208) 237-5631
LOCATION: MISSION ROAD
FAX (208) 237-5796

TRIBAL HEALTH & HUMAN SERVICES DEPARTMENT

P.O. BOX 306
FORT HALL, IDAHO 83203
FAX (208) 238-3940

October 3, 2014

Linda Hatzenbuehler
Idaho State University
Division of Health Sciences
921 South 8th Ave., Stop 8055
Pocatello, Idaho 83209-8055

RE: Idaho Council on Suicide Prevention

Dear Dr. Hatzenbuehler:

On behalf of the Shoshone-Bannock Tribes, as the manager for the Mental Health Program, I would like to report activities/events that our Tribe has provided and/or participated in this year to meet the goals of the Idaho Suicide Prevention Plan.

- Two mental health providers for the Tribe become Certified ASIST (Applied Suicide Intervention Skills Training) Trainers (Goal 4)
- Provided two, two day ASIST trainings to community members, 20 people completed (Goal 3 & 5)
- Hosted 1st Annual "Walk For Life" Suicide Awareness/Prevention activity- National campaign throughout Indian Country (Goal 1 & 2)
- Participated in THRIVE (Tribal Health Reaching Out InVolves Everyone) media campaign to prevent suicide and bullying among American Indian/Alaska Native Youth (Goal 1 & 2)
- Disseminated Suicide Hotline information out to all the Tribes in Idaho and hang posters throughout the Indian Health Service Center and the community (Goal 8 & 1)
- Participated in the State Juvenile Justice grant, provided Mental Health screenings to 65% or more of adolescents entering the Fort Hall Corrections (Goal 4 & 6)

Respectfully,

Krissy Broncho, LCSW
CFS Manager/Clinical Coordinator

NAMI Idaho

On September 20, 2014, NAMI Idaho held their quarterly Regional Conference in Coeur d'Alene Idaho. Because of NAMI Idaho's recognition of the importance of suicide prevention within the state, and our formal position that suicide prevention is the responsibility of the entire community and requires vision, will, and a commitment from the state, communities and individuals of Idaho, a formal Question, Persuade, Refer (QPR) training was included in the conference schedule. The QPR (Question, Persuade, and Refer) Gatekeeper Training for Suicide Prevention is a brief educational program designed to teach "gatekeepers"--those who are strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers)--the warning signs of a suicide crisis and how to respond by following three steps:

- Question the individual's desire or intent regarding suicide
- Persuade the person to seek and accept help
- Refer the person to appropriate resources

More than 25 individuals were trained on warning signs and referral techniques for use in their communities. It is hoped that this training can be incorporated into all future NAMI Idaho Regional Quarterly Conferences within the state of Idaho.

2014 QPR Community Support Funded by Governor's Council on Suicide Prevention

Question, Persuade and Refer (QPR) is a short training designed to teach individuals how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. This year the Council provided 472 QPR training booklets, free of charge, to five trainers who would otherwise have had to charge attendees or pay out of their own pocket.

The Suicide Prevention Council also funded recertification of six (6) QPR Trainers (from all corners of the state of Idaho). Below is a list of the individuals recertified and the conditions agreed upon in exchange for the funding.

The following QPR Instructors were recertified with Council Funds:

1. Jeni Griffin- Idaho Falls, ID
2. Kim Kane- Boise, ID
3. Penelope Hansen- Boise, ID
4. Kristin Gorringer- CDA, ID
5. Kim Jardine-Dickerson- Idaho Falls, ID
6. Cynthia Mauzerall - Boise, ID

- 1. Conduct a minimum of 3 QPR trainings within the first year starting at the recertification date.*
- 2. Each QPR training must have a minimum of at least ten (10) participants, not including the trainer.*
- 3. The QPR trainer needs to send a report via e-mail to the Council of dates, times, locations, and number of training participants of each QPR training.*



SUICIDE PREVENTION ACTION NETWORK OF IDAHO

ACTIVITIES AND ACCOMPLISHMENTS

October 2014

Overview

SPAN Idaho is a suicide prevention organization founded in 2002 as a 501 (c) (3) nonprofit organization. Our mission is to provide leadership for suicide prevention in Idaho. At the state level, SPAN Idaho comprises a volunteer board of directors and two part-time staff, with established chapters in each of the seven Idaho Department of Health and Welfare (IDHW) regions to carry out statewide suicide prevention awareness activities and to respond at a community level. From its beginning, Span Idaho as a grassroots organization has encouraged and recognized the importance of regional and local involvement to prevent suicide. With the help of our chapters and other organizations, SPAN Idaho works to have zero suicides in our state.

Most Recent

In partnership with Idaho State Department of Education (SDE), SPAN Idaho received the Garrett Lee Smith Memorial Act (GLSMA) grant administered by the substance Abuse and mental Health Services Administration (SAMHSA) to target youth, ages 10-24 in suicide prevention in October of 2013. The Idaho Lives Project (ILP), which will reach more than 31,000 individuals over the three-years of the grant, with training for youth, school staff, community adults along with health and mental health providers in effective response to suicidal youth. All goals of the project align with the goals of the Idaho Suicide Prevention Plan (ISPP) and the National Strategy for Suicide Prevention (NSPP). More about this project is included in this current report.

Training and Awareness

SPAN Idaho and its chapters consistently provide or co-host a variety of community activities to educate the public about suicide and suicide prevention. For instance, we

- Offer training for clinicians, survivors, police/sheriff departments, and anyone interested in suicide prevention. As of September 2014, SPAN Idaho's annual statewide conferences the last thirteen years have trained approximately 2,500 participants in suicide prevention skills. Our most recent conference, held in September 2014, Dr. Thomas Joiner one of the world's leading experts in suicide prevention shared his expertise to a group of mental health professionals, clergy, school personnel, survivors, law enforcement, and community leaders. His valuable and up to date, best practices training, educated more than 150 individuals in suicide prevention.
- Developed and conducted presentations and trainings on suicide and suicide prevention for the Idaho Department of Labor, Idaho Criminal Justice Commission, IDHW Children's Mental Health, Idaho Juvenile Justice, Idaho State Tax Commission, Hispanic Commission, Idaho National Guard, schools, parent groups, clergy, and other community groups.
- Hold regional annual Save-the-One Memorial Walks to raise awareness and support survivors.
- Provide materials at community events and gatherings to share suicide warning signs and other prevention measures.

MENTAL HEALTH FIRST AID SCHEDULE 2014-2015

Month	Place	Location	Reg.
Aug.25 th 26 th	Salmon, Idaho	Public Library 204 Main St.	7
Sep. 18 th 19 th	Sandpoint, Idaho	Bonner General Hospital 520 N 3rd Ave. Sandpoint, Idaho 83864	1
Oct. 2nd 3rd	Idaho City, Idaho	Idaho City Community Hall 206 West Commercial Idaho City, Idaho	4
Nov. 6th 7th	Grangeville, Idaho	Real Life Church(The Gym) 1005 E Main St Grangeville, Idaho	2
Dec.			
2015			
Jan.			
Feb. .5 th 6 th	3402 Franklin Rd. Caldwell, Idaho Spanish Edition	IDHW 3402 Franklin Rd Caldwell, Idaho 83605	3
Mar. .19 th 20 th	Weiser	TBD	3
Apr. 16 th 17 th	Montpelier, Idaho	Bear Lake Memorial 164 S. 5th St. Montpelier, Idaho 83254	6
May 14 th 15 th	Shoshone, Idaho	TBD	5
Jun.	Duck Valley Indian Reservation	???????	3
July 30 th 31 st		TBD	

Here is the schedule for the rest of this year and next year. The Duck Valley Indian Reservation will be getting back to me on if they want June or July.

Teen Suicide Prevention & Mental Health Discussions Model

The pilot Teen Suicide Prevention & Mental Health Discussion session was held in April 2014. About 15 teens attended, responding to notices placed on websites, information distributed to school counselors, advocacy groups, and word of mouth.

The pilot project was offered in the Treasure Valley to obtain a convenience sample of comments and to test the model for potential duplication in other areas of the state in subsequent years. Lessons learned are listed below.

Council member Amanda Wester and her mother, Laura, and Council Member Ann Kirkwood organized the event over a 3-month period. Amanda's involvement was essential as she kept the program grounded in the interests and needs of teens. Laura prepared letters to parents, school counselors, the flyer and posted the information on many websites frequented by teens in the Treasure Valley. Both Amanda and Laura maintained working relationships with SPAN Boise and the Idaho Federation of Families for Children's Mental Health. Ann was responsible for securing a location, preparing a facilitator's guide, training the facilitators, and making arrangements for refreshments.

The Council budgeted \$800 for the event. Because the session did not meet state requirements for food purchase, IDHW was not able to cover costs of food. As a result, with Kathie Garrett's assistance, the Federation of Families generously purchased pizza and drinks for the event. Dessert was made up of M&M's, a popular addition to the menu! Idaho State University, Meridian Health Science Center, generously donated space for the event, avoiding the need to rent a location. As a result, there were no costs charged to the Council's budget. IFFCMH and ISU were listed as event co-sponsors.

Ann also approached ISU to provide facilitators from among its Masters in Counseling students and one student (Cheyenne Jones) volunteered for the project. Amanda and Susan Delyea from IFFCMH also served as facilitators. Two professional counselors also were approached to volunteer, but arrangements fell through the day before the event. As a result, Cheyenne's expertise in counseling was needed to support one teen who, while not suicidal, had a history of mental health concerns.

Teens 16 and older were allowed to register online. They provided their addresses and a letter was sent to their parents/guardians before the event. The letter notified parents/guardians that their child had signed up and described the purpose of the session. Parents were encouraged to speak with their teens before and after the event. We received no responses or concerns from parents about the event.

Highlights from the teens' comments were:

- We don't feel heard by adults, including parents, teachers, church leaders, etc.
- Adults dismiss and blow off their feelings because they "aren't as important" as whatever it is that adults have going on.

- Select facilitators who are young adults so that teens will feel comfortable
- Ask facilitators to do the "report outs" from groups to summarize the discussions so the entire group can discuss further
- Older adults should leave the room during facilitated discussions
- Tell teens that the counselors are on hand and where they will be if help is needed; have the counselors agree to stay at least a half hour after close
- Don't get too large; our event was just the right size for an intimate discussion (3 groups of 5). We could have expanded to a fourth group of 5, but would not want to go larger than that

The following page is the Facilitator's Guide used for the discussions.

10. What are the key things you want adults to **know about** suicide among teens? **AND Why?**
11. What are the key things you want adults to **DO** about suicide among teens? **AND Why?**
12. Why were you interested in coming here tonight?
13. Is there anything else you want to tell us that we haven't asked about?

NOTES TO FACILITATORS:

- The input needs to be as detailed and dense as possible.
- Please take complete, detailed notes that are legible.
- If your handwriting is hard to read, please stay afterward and make it clear so the person who writes the final report can read it easily.
- If you are not getting robust discussion, use the following:

Prompts

Tell me more....
How would that work...
What would the desired outcome be...
How would that help...
How does that make people feel...
What would that mean for teens...

QUESTIONS FOR FACILITATORS: Please complete the following...

1. Do you think the teens felt heard and valued?
_____ Yes _____ No
2. Why?
3. How would you recommend the focus groups be improved if they're done again?



1-800-273-TALK (8255)

Suicide in Idaho

Idaho is consistently among the states with the highest suicide rates. In 2012 (the most recent year available) Idaho had the 8th highest suicide rate, 44% higher than the national average.

- In 2013, 308 people completed suicide in Idaho; a slight increase from 2012.
- Between 2009 and 2013, 79% of Idaho suicides were by men.
- In 2013, 65% of Idaho suicides involved a firearm. The national average is 51%.
- 15.8% (1 in 7) of Idaho youth attending regular public and charter high schools reported seriously considering suicide in 2013. 7.0% (1 in 14) reported making at least one attempt.
- A ten percent (10%) reduction in Idaho suicide attempts can immediately save over \$4 million per year in medical costs alone. If the cost burden of suicide in Idaho was evenly distributed over the population (2008) the burden would amount to over \$250 for every person living in Idaho (Piland, 2010).

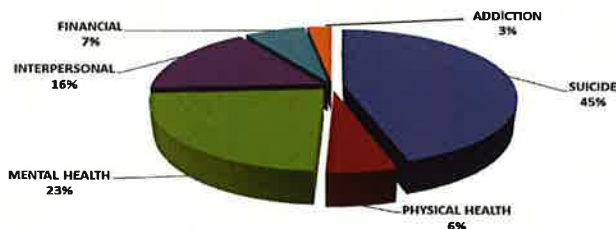
Staffing Information

- ISPH has 47 trained volunteers. Volunteers contributed a total of 9836 hours in 2014, an approximate in-kind value of \$179,053.
- Current staff consists of one full time Project Director, a part time Volunteer Coordinator, a full time phone room supervisor, 6 part time phone room supervisors and an Americorp Volunteer (7.18 FTE).

2015 Program Goals

- Incremental implementation of text/ chat response in addition to existing phone response.
- Increase level of volunteer staffing and statewide launch of Hotline Ambassador Program.
- Continue to implement sustainable funding strategies.
- Continue to increase statewide awareness of Hotline.

Caller Issues 2014



"So many lives are touched by suicide, including mine. But I have long believed that we are given adversity as a teacher, as a path toward empathy, and as a tool. So I didn't hesitate to sign up as a volunteer for the new Idaho Suicide Prevention Hotline. It was a huge relief to learn that we would be properly trained; that we would have professional supervisors to guide us as needed; that there would be support on the hotline calls and their after-effects. And none of this went undone. I feel cradled by my peers and especially by the Hotline staff."

Call Statistics

Idaho Suicide Prevention Hotline

Call Statistics

October 1 to December 31, 2014

	4th Quarter	Year to Date
Total Calls Received	10	2869
Military Members / Families	22	660
Rescue Calls (approximate)	4	147
Caller Age:		
10 - 14	20	94
15 - 19	10	311
20 - 24	95	238
25 - 34	13	307
35 - 44	62	160
45 - 54	11	285
55 - 64	19	565
65 - 74	18	84
75 - 84	6	21
85+	0	5
Didn't Report	25	799
Total Calls Received		2869

Idaho Suicide Prevention Hotline

Calls by County

October 1 to December 31, 2014

County	4th Quarter	Year to Date	County	4th Quarter	Year to Date
Ada	303	810	Idaho	0	5
Adams	2	11	Jefferson	4	5
Bannock	39	138	Jerome	17	49
Bear Lake	3	6	Kootenai	171	477
Benewah	12	22	Latah	28	78
Bingham	12	32	Lemhi	0	3
Blaine	10	23	Lewis	1	3
Boise	8	34	Madison	8	25
Bonner	25	50	Minidoka	3	11
Bonneville	50	138	Nez Perce	20	39
Boundary	1	1	Owyhee	4	11
Butte	0	6	Payette	8	20
Canyon	86	287	Power	8	17
Caribou	1	3	Shoshone	7	18
Cassia	9	20	Teton	1	4
Clearwater	1	8	Twin Falls	43	100
Custer	0	4	Valley	7	12
Elmore	5	19	Washington	2	10
Franklin	2	17	Unknown	1	1
			Caller Refused/Unable to Collect Data	60	232
Fremont	0	2			
Gem	8	14	*Other	26	90
	5	14	Total Calls Received	1001	2869
Gooding					

*Calls from out of state callers with 208 area coded cell phone numbers

**Introduction for Becky diVittorio, Executive Director, Optum Idaho
Idaho Senate/House Committee on Health and Welfare**

My name is Becky diVittorio and I am the Executive Director for Optum Idaho.

Thank you for allowing me the opportunity to discuss the progress that has been made in helping Idahoans get the behavioral health care services they need. Since last year, some new faces have been added to this committee so I would like to share some background on Optum and what we are working to achieve in Idaho.

The State of Idaho hired Optum in September 2013 to manage the outpatient mental health and substance use services for people enrolled in the Idaho Behavioral Health Plan. I have been with Optum Idaho since we started our work here and I can truly say this has been an incredibly rewarding experience because it's an opportunity to advance Idaho's system of care and take it to the next level for people who need our support. In partnership with the state, we are enhancing the system by linking more people to the care they need based on nationally recognized evidence-based medical practices that have proven to work. I know change is not easy. I call what we are doing disruptive innovation. The disruptive part is hard but the innovation is exciting and rewarding.

Before I begin my presentation, I would like to introduce Craig Herman, the Senior Vice President for Optum who oversees the work we do and provides national support to ensure that we continue to execute our best work. Also joining me is Optum Idaho's clinical director Dr. Dennis Woody. Dr. Woody is an Idahoan and

has worked in the Idaho behavioral health system for more than 25 years. He is responsible for leading Optum Idaho's clinical program to ensure people are getting high quality and appropriate services.

At Optum Idaho, we are helping people reach recovery by getting them the outpatient care they need at the right time and place, and ensuring efficient, effective use of Idaho taxpayer dollars. Our work is done in partnership with members, providers, the state and community partners.

In the next few minutes I'll talk about our progress and the goals we have for 2015 and beyond.



Idaho Behavioral Health Plan Update:
Senate Health and Welfare Committee
January 27, 2015

Attachment 4

Agenda

- I. System Transformation
- II. Outcomes
- III. Our Work Ahead

Evidence-Based Practices

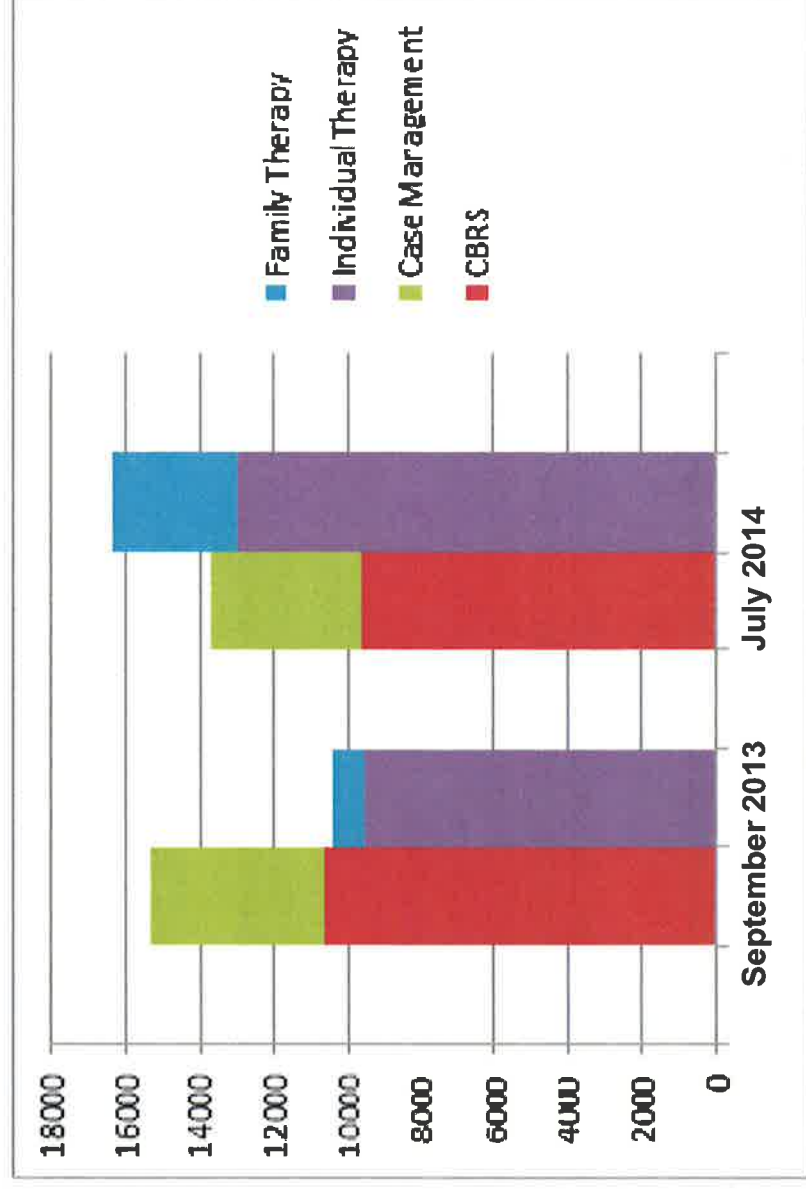
- Evidence-based practices are interventions that are known to work.
 - The U.S. Surgeon General, the Institute of Medicine (IOM) and the President's New Freedom Commission Report on Mental Health call for the broad use of evidence-based practices to help improve care.
 - According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), in the behavioral health field, the term evidence-based practices refers to interventions that have been **rigorously tested, have yielded consistent, replicable results, and have proven safe, beneficial, and effective** for most people diagnosed with mental illness and substance use disorders.
- Evidence-based guidelines for the behavioral health field are provided by the:
 - American Psychiatric Association
 - American Academy of Child and Adolescent Psychiatry
 - and governmental sources such as SAMHSA, Centers for Medicare and Medicaid Services and the U.S. Department of Veterans Affairs

Clinical Excellence Spotlight: Evidence-Based Practices

From September 2013 through July 2014:

- The number of members accessing individual therapy increased 36%.
- The number of members accessing family therapy more than tripled.

Members Accessing Care – Service Comparison



Strengthening Communities Spotlight: Mental Health First Aid

Mental Health First Aid is recognized by SAMHSA as an evidence-based practice for communities.

In rural communities, Mental Health First Aid has been shown to:

- Increase understanding of mental illness.
- Improve participants confidence in helping those in a mental health crisis.
- Changed attitudes and behaviors towards those with a mental health issue.

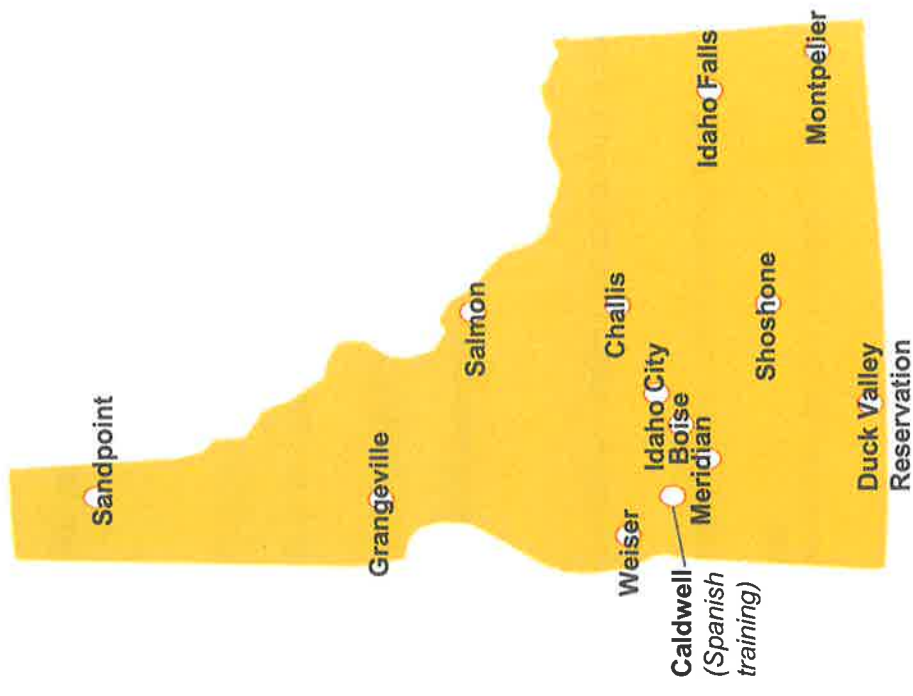
“...empathy toward clients presenting with mental health issues has improved as a result of this training. I do thank Optum Idaho for offering it and especially in our community.”

- Grangeville provider whose non-clinical staff attended training.

Sources: Mendenhall AN, Jackson SC, Hase S. **Mental Health First Aid USA in a rural community: Perceived impact on knowledge, attitudes and behavior.** *Social Work in Mental Health*, 2013.



Mental Health First Aid Trainings: 2014-2015



Enhancing Programs and Services

Challenges and opportunities

- Nationally recognized peer support program was not a reimbursed benefit under Medicaid.
- There was a need for additional support for families.
- While Optum only manages the outpatient system, we identified the opportunity to help members transition from inpatient levels of care back to their community.

Changes Optum made

- Peer support services are now an available benefit under the Idaho Behavioral Health Plan.
- Developing new services to help families understand and navigate the mental health and substance abuse treatment system.
- Created new community transition services that provides in-home support, assists with outpatient follow-up appointments and helps people who were hospitalized work effectively with their treatment providers.

Results

- Since April 2014, more than **1,200 members** have accessed the new peer support service benefit and that number continues to grow.

Our Work Ahead

- Implement evidence based practices
- Expand the array of covered services with value added benefits
- Engage consumers in recovery & resiliency
- Enhance the crisis response system
- Strengthen the role of stakeholders in system design
- Build healthy relationships



Thank You.





Optum Idaho | Fact Sheet

January 2015

Optum Idaho manages outpatient behavioral health benefits for Idaho Medicaid members. Optum works closely with the State and its behavioral health care providers to ensure limited taxpayer dollars are used to help Idahoans get the right treatment at the right time and place.

New Programs and Services

Since beginning its contract to manage outpatient behavioral health services for Idaho Medicaid beneficiaries, Optum has added new programs and services including:

- Introducing peer support as a covered benefit under Medicaid. A peer support specialist is someone who has managed their own behavioral health issue and is now in recovery. The specialist helps people experiencing a behavioral health issue connect with additional services and resources in the community.
- Enhancing access to care by having psychiatric nurse practitioners added as a resource to provide telepsych services. Telepsychiatry makes care available to members through web conferencing, allowing a face to face interaction through technology. This service is vital in treating members who may otherwise not seek treatment because of long distance travel or inclement weather.
- Creating a new Member Access and Crisis Line, a free 24-hour, seven-day-a-week service that provides support and referrals to people experiencing a mental health or substance use crisis.
- Providing access to online trainings to ensure that providers, especially those in rural areas, have the ability to continue their education in their communities without travel.
- Continuing to conduct Mental Health First Aid trainings for communities statewide at no cost to participants. These trainings teach people how to help someone experiencing a mental health crisis. Much like CPR can help someone experiencing a heart attack, Mental Health First Aid has been shown to help someone in crisis get the assistance they need until professional staff arrives.

Increasing Access to Care

- Optum introduced peer support as a covered benefit under Medicaid. A peer support specialist is someone who has managed their own behavioral health issue and is now in recovery. The specialist helps people experiencing a behavioral health issue transition smoothly back to their community and connect with additional services after being discharged from a hospital or in-patient facility. Here are examples of how Optum has worked toward transitioning members to evidence-based care and how that can positively change the course of their recovery journey by accessing peer support services:
 - *Since I got the help from my Peer Support Specialist (PSS), it has changed my life. If I didn't have this service, I would be right back where I was. I thank everyone for those who have helped me. In the last month I have come a long way. I can't dwell on the past. I need to move forward. If I needed to talk to someone, I knew I could call my PSS. It gives me hope. If I didn't have it, I would be at the corner bar.*
 - *Peer Support Specialists understand with their hearts not their brains. I like to talk to someone who has been there rather than reading it out of a book. I am by myself and the PSS is there when I am lost, alone, and empty. I know they are there for me to talk to. I want someone to be straight up with me and not beat around the bush.*
- Optum helps people get the most effective care based on best practices established by the national medical and behavioral health communities, including the Substance Abuse and Mental Health Services Administration (SAMSHA), the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA).
- Since Optum started working with behavioral health providers in Idaho in 2013, the use of evidence-based practices, such as individual and family therapy, has increased significantly. The positive results in Idaho include:
 - Through July 2014, the number of members accessing individual therapy has increased by 36% since Optum's contract began.
 - Through July 2014, the number of members accessing family therapy has more than tripled since the beginning of the contract.

Local Office and Staff

- Optum Idaho's main office is in Meridian and currently has more than 40 staff members.
- Optum's regional staff live and work in communities throughout the state so they can establish effective local relationships.

Contact Information

Becky diVittorio, Executive Director, Optum Idaho
(208) 914-2012
rebecca.divittorio@optum.com



Idaho Behavioral Health Plan



Regional Snapshot | REGION 1

January 2015

- Number of Unique Members living in Region 1: 34,210
- Number of Unique Members living in Region 1 that have accessed services through the Idaho Behavioral Health Plan since January 2014: 5,391
- Percentage of all Idaho Behavioral Health Plan members represented in Region 1: 12.79%
- Mental health clinicians per 1000 Idaho Behavioral Health Plan members in Region 1: 20.87 (Statewide: 14)
- Prescribers per 1000 Idaho Behavioral Health Plan members in Region 1: 2.43 (Statewide: 2.20)
- Substance Abuse Groups per 1000 Idaho Behavioral Health Plan members in Region 1: .76 (Statewide: .61)



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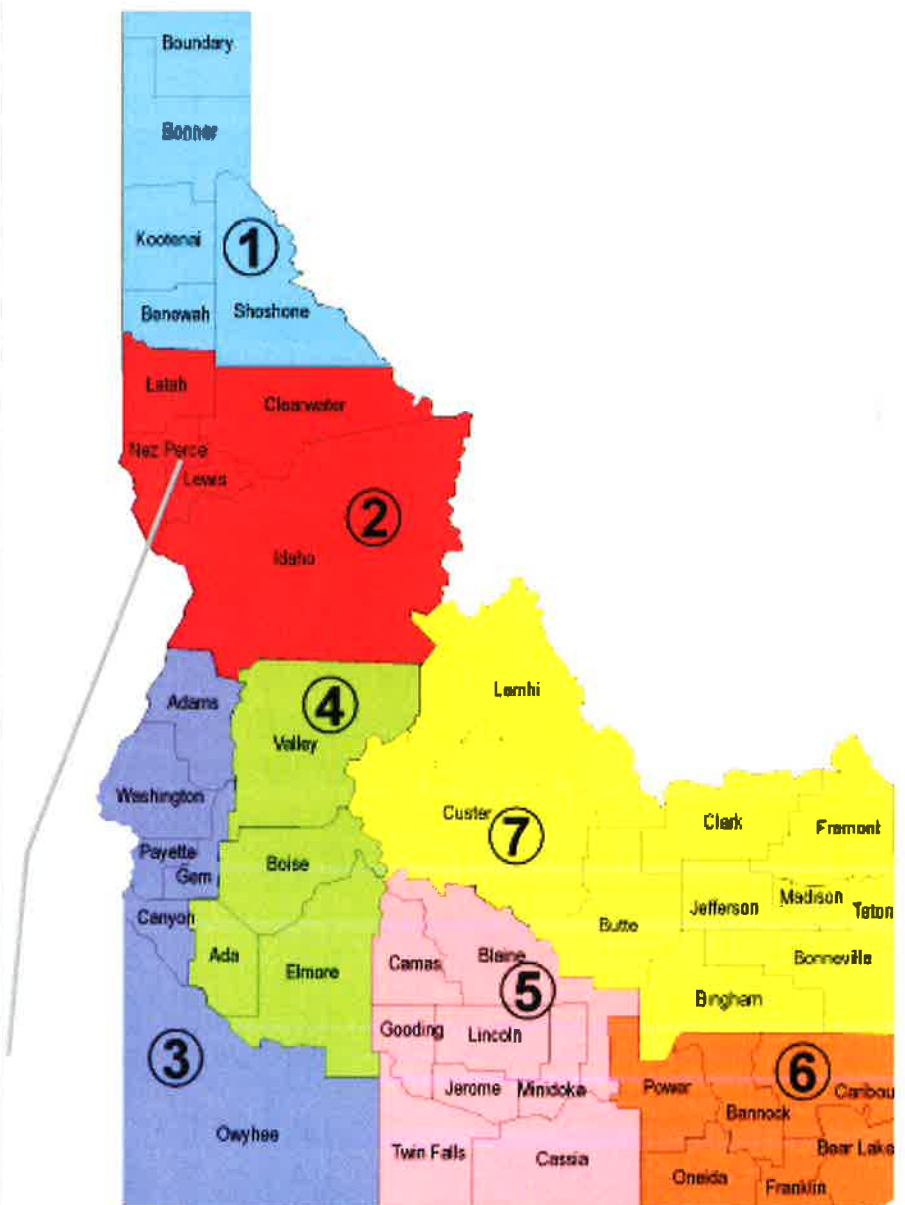
Idaho Behavioral Health Plan



Regional Snapshot | REGION 2

January 2015

- Number of Unique Members living in Region 2: 13,441
- Number of Unique Members living in Region 2 that have accessed services through the Idaho Behavioral Health Plan since January 2014: 1,728
- Percentage of all Idaho Behavioral Health Plan members represented in Region 2: 5.02%
- Mental health clinicians per 1000 Idaho Behavioral Health Plan members in Region 2: 14.43 (Statewide: 14)
- Prescribers per 1000 Idaho Behavioral Health Plan members in Region 2: 2.23 (Statewide: 2.20)
- Substance Abuse Groups per 1000 Idaho Behavioral Health Plan members in Region 2: .81 (Statewide: .61)



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Idaho Behavioral Health Plan



Regional Snapshot | REGION 3

January 2015

- Number of Unique IBHP Members living in Region 3: 58,556
- Number of Unique Members living in Region 3 that have accessed services through the IBHP since January 2014: 9,116
- Percentage of all IBHP members represented in Region 3: 21.89%
- Mental health clinicians per 1000 IBHP members in Region 3: 10.14 (*Statewide: 14*)
- Prescribers per 1000 IBHP members in Region 3: 1.84 (*Statewide: 2.20*)
- Substance Abuse Groups per 1000 IBHP members in Region 3: .51 (*Statewide: .61*)



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Idaho Behavioral Health Plan



Regional Snapshot | REGION 4

January 2015

- Number of Unique Members living in Region 4: 56,917
- Number of Unique Members living in Region 4 that have accessed services through the Idaho Behavioral Health Plan since January 2014: 10,956
- Percentage of all Idaho Behavioral Health Plan members represented in Region 4: 21.27%
- Mental health clinicians per 1000 Idaho Behavioral Health Plan members in Region 4: 19.2 (Statewide: 14)
- Prescribers per 1000 Idaho Behavioral Health Plan members in Region 4: 3.5 (Statewide: 2.20)
- Substance Abuse Groups per 1000 Idaho Behavioral Health Plan members in Region 4: .37 (Statewide: .61)



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Idaho Behavioral Health Plan



Regional Snapshot | REGION 5

January 2015

- Number of Unique Members living in Region 5: 35,847
- Number of Unique Members living in Region 5 that have accessed services through the Idaho Behavioral Health Plan since January 2014: 4,491
- Percentage of all Idaho Behavioral Health Plan members represented in Region 5: 13.40%
- Mental health clinicians per 1000 Idaho Behavioral Health Plan members in Region 5: 6.02 (Statewide: 14)
- Prescribers per 1000 Idaho Behavioral Health Plan members in Region 5: .7 (Statewide: 2.20)
- Substance Abuse Groups per 1000 Idaho Behavioral Health Plan members in Region 5: .56 (Statewide: .61)



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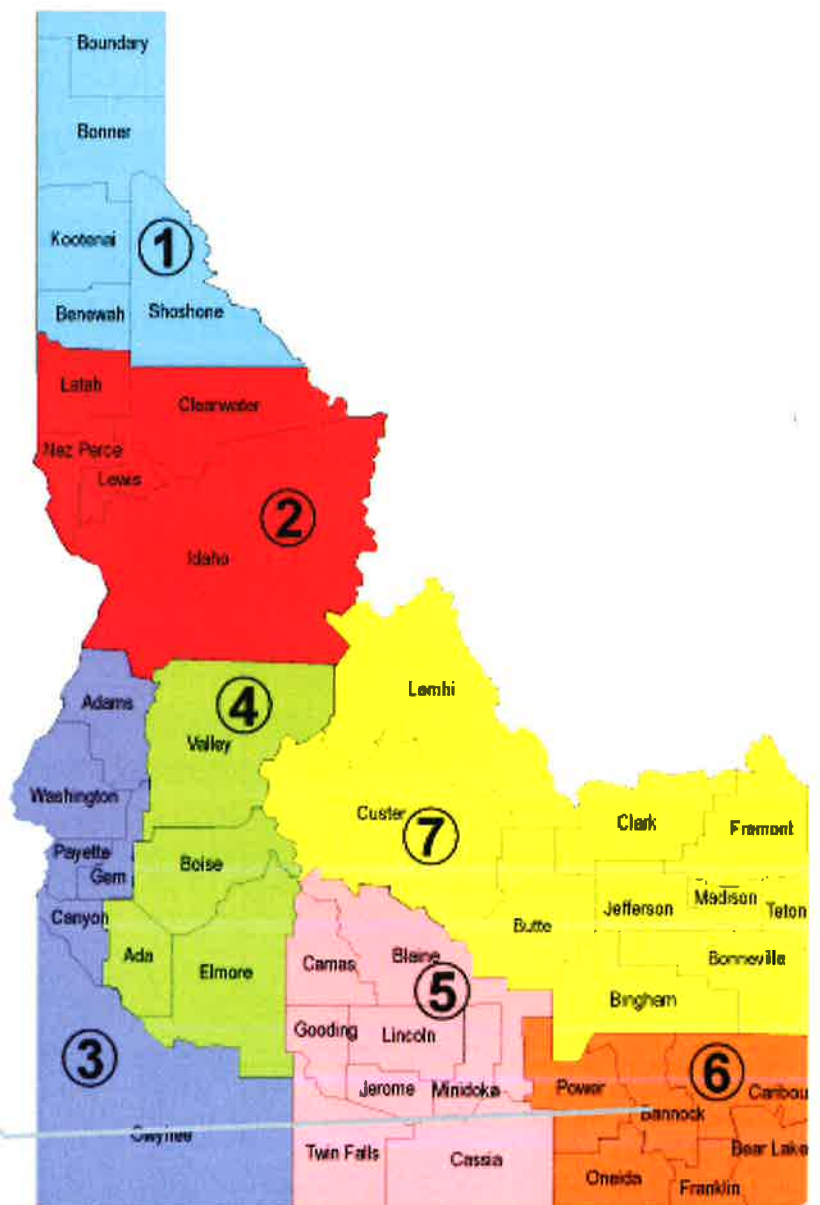
Idaho Behavioral Health Plan



Regional Snapshot | REGION 6

January 2015

- Number of Unique Members living in Region 6: 21,767
- Number of Unique Members living in Region 6 that have accessed services through the Idaho Behavioral Health Plan since January 2014: 3,523
- Percentage of all Idaho Behavioral Health Plan members represented in Region 6: 21.89%
- Mental health clinicians per 1000 Idaho Behavioral Health Plan members in Region 6: 14.88 (Statewide: 14)
- Prescribers per 1000 Idaho Behavioral Health Plan members in Region 6: 2.29 (Statewide: 2.20)
- Substance Abuse Groups per 1000 Idaho Behavioral Health Plan members in Region 6: 1.01 (Statewide: .61)



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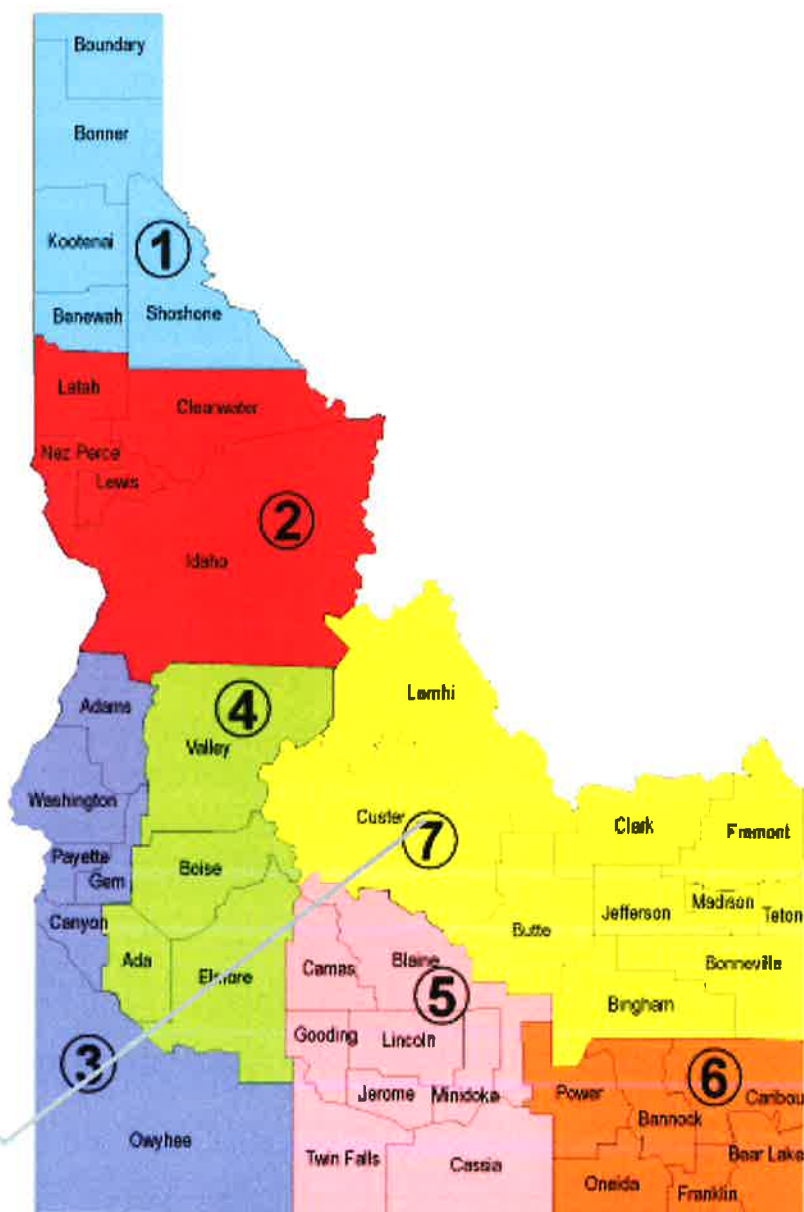
Idaho Behavioral Health Plan



Regional Snapshot | REGION 7

January 2015

- Number of Unique Members living in Region 7: 46,659
- Number of Unique Members living in Region 7 that have accessed services through the Idaho Behavioral Health Plan since January 2014: 8,153
- Percentage of all Idaho Behavioral Health Plan members represented in Region 7: 17.44%
- Mental health clinicians per 1000 Idaho Behavioral Health Plan members in Region 7: 10.63 (Statewide: 14)
- Prescribers per 1000 Idaho Behavioral Health Plan members in Region 7: 1.69 (Statewide: 2.20)
- Substance Abuse Groups per 1000 Idaho Behavioral Health Plan members in Region 7: .66 (Statewide: .61)



OPTUM

Idaho Behavioral Health Plan

Collaborative Adult Work Group System Changes Reference Checklist – 2013/2014 December 3, 2013

HOW TO USE THIS CHECKLIST

The following list of questions are to be used as a reference to help ensure proposed and implemented changes to the Adult Developmental Disabilities system respond to the needs, priorities and suggestions identified by the Collaborative Work Group. In posing these questions, the Collaborative Work Group recognizes regulatory requirements and fiscal constraints may affect the extent to which any of these can be implemented. However, Collaborative Work Group recommends any systems change consider how it does, to the extent feasible, best respond to the following questions. The goal is to intentionally improve the system to achieve the vision, and to specifically not harm what currently exists.

Subsequent pages provide a list of parameters respective to Medicaid rules and key definitions. Another checklist specific to participant needs, priorities and suggestions is pending.

In the development of our recommendations for and implementation of a Developmental Disabilities system for adults, have we ensured, to the extent possible . . .

- . . . a) the two eligibility processes include steps to effectively cross-reference other eligibility processes (Aged & Disabled Waiver, Developmental Disabilities Waiver, Intermediate Care Facilities for Individuals with Intellectual Disabilities, Intermediate Care Facilities for Individuals with Developmental Disabilities) with which an individual may also be involved?

- ... b) services (or service packages) are flexible and easy to adapt to an individual's changing needs?
- ... c) the individual budget process addresses all needs identified in the "person center planning" meeting, including those that fall outside of
 - a. "Medically necessary"? – *(See definitions below)*
 - b. "Health and safety"? - *(No definitions provided)*
- ... d) the individual budget process and person centered planning process work together to best meet individual needs?
- ... e) DHW clinical review processes collaborate more effectively with the person centered planning process? – *(See definitions below)*
- ... f) long-term employment supports are available to all individuals?
- ... g) specified services are governed by the same rules and regulations regardless of who is providing the service?
- ... h) reimbursement rates cover all costs incurred with providing services?
- ... i) billing procedures are structured in a user-friendly way that minimizes billing errors?
- ... j) regulations ...
 - ... 1) around data collection avoid duplication and enhance training?
 - ... 2) involving oversight of para-professional staff avoiding duplication and enhance training?
 - ... 3) allow services to include recreation and exercise?
 - ... 4) accommodations and additional dollars are in place to support services provided in rural areas?
- ... k) our provider network system offers career opportunities for both professionals and para-professionals featuring benefits, living wages and training?
- ... l) an effective communication system provides consistent information between different services?
- ... m) our system actively pursues a communication, outreach and information center that effectively brings best practices and progressive thought to all service providers and facilitates a shared understanding of the service delivery system?

Definitions

- 1. Person Centered Planning**
- 2. Medically Necessary**
- 3. Health and Safety**
- 4. Quality Services**
- 5. Quality Personnel**

Definitions from Centers for Medicare & Medicaid Services Idaho Administrative Procedures Act:

Person Centered Planning

Centers for Medicare & Medicaid Services Technical Guide - An assessment and service planning process is directed and led by the individual, with assistance as needed or desired from a representative or other persons of the individual's choosing. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and nonpaid services and supports that assist him/her to achieve personally defined outcomes in the community.

Idaho Administrative Procedures Act - A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service.

Medically Necessary

Centers for Medicare & Medicaid Services Technical Guide - Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of the condition, and meet the standards of good medical practice

Idaho Administrative Procedures Act - A service is medically necessary if:

- a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and

- b.** There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly.
- c.** Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request.

Health and Safety, Quality Services and Quality Personnel – no specified definitions from Centers for Medicare & Medicaid Services or the Idaho Administrative Procedures Act

Medicaid Parameters

Medicaid is required to use CPT and HCBS procedure codes for billing. These codes are nationally recognized and are required by CMS. Each code comes with a description of the service. Instructions included as part of the description often identifies the minimum qualification of the provider and the billable unit.

Self-Direction services are not defined the same way and are therefore not subject to the same requirement.

Reimbursement rates are tied to the qualifications of the provider, and are established by the State of Idaho through a stated process.

Services purely diversional and recreational in nature fall outside the scope of HCBS waiver services. However, social and recreational programming is allowable. It is the intent of the service (socialization vs. diversion) that makes the difference.

Currently, medical necessity and health and safety requirements are a part of the exception review process. This criterion is applied to service requests that exceed the assigned budget. Exception review is attached to the current system – if redesigned, this may become moot.

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APPENDIX B: STATE MATRIX

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Supports and Services State Comparisons – pg 1

Current Services	Idaho 1915i	Michigan 1915 b/c School age 26	Arizona 1115, 1915K PCS-self dir.	Rhode Island 1115 Has wait list	New Mexico 1915I & 1915c	New York 1915 b/c?	Colorado 1915c	Wyoming 1915c Has Wait list 2-3 yrs	Oregon	North Carolina 1915 b/c
Adult Day Care	X	X Waiver b/c			X C waiver?		X SLS waiver	Looks like no	See dev. therapy	X
Behavioral & Crisis Mgt.	X	X State plan	X		X C waiver	X Clinics article 16	X SLS waiver		X	X
Chore Services	X	X Waiver b/c					X			
Developmental Therapy	X	X Waiver b/c includes pre-voc	X Day treatment	X Includes pre-voc	X C waiver – customized community	X Comm. & center Day services	X - SLS waiver Include pre-voc Spec. Habilit. & Comm. Connection	X waiver	X pre-voc, comm. Acc. & day services	X Day supports, community networking
Emergency Response	X	X Waiver b/c		X w/in res support	X C waiver		X SLS waiver	X waiver		X
Environmental Modifications	X	X Waiver b/c	X	X waiver	X C waiver	X	X SLS waiver includes vehicles	X waiver		X
Home Choice (MFP)	X				X		X	X	X	X Community Transition
Home Delivered Meals	X	X Waiver b/c					X MFP - 2013			
ICF/ID	X	X State plan	X Group home	X Waiver 24 hr res hab		X	X Group home 4-8	X waiver	X Group Home	X Group Home
Medication Mgt.	X	X State plan	X		X State plan	X	X MFP - 2013	X Waiver Tele-med	X	
Nursing Services	X	X Waiver b/c	X		X C waiver	X	X MFP - 2013	X waiver	X	
Therapies – OT, PT, Speech etc.	X	X State plan	X		X State plan		X State plan	X waiver	X	

Supports and Services State Comparisons – pg 2

Current Services	Idaho 1915i	Michigan 1915 b/c School age 26	Arizona 1115, 1915K PCS-self dir.	Rhode Island 1115 Has wait list	New Mexico 1915i & 1915c Has wait list	New York 1915 b/c?	Colorado 1915c	Wyoming Has Wait list 2-3 yrs	Oregon	North Carolina 1915 b/c
Personal Care Services	X	X State plan		X waiver			X SLS waiver	X waiver		X
Psycho-Therapy	X	X State plan	X			X	X		X 1915(i)	
Psychosocial Rehab (PSR)	X	X State plan	X				X MFP – 2013		Not sure	
Residential Hab. Certified Family/ Supported Living	X	X Comm. living b/c Home-based state plan	X Habitatation Adult dev. home	X Waiver Shared living & 24 hr res hab	X C waiver Special medical home	X Certified family & Supported living	X Certified family & Supported living	X Waiver Group & Indv. Supported	X Waiver	X In home skill building, intense support and res. support
Respite	X	X Waiver b/c	X	X Short term	X State plan	X Self-directed	X SLS waiver	X State plan	X	X
Self-Directed Services	X	X Waiver b/c Choice Voucher	X		X C waiver	X Includes respite	X Attendant in-home support	X Waiver Agency w/Choice	X	X 2 models: Agency w/choice and Employ of Record
Service Coordination	X	X State plan	X waiver	X waiver	X State plan	X	X State plan?	X waiver	X	X Community Guide Services
Specialized Medical Equip.	X	X Waiver b/c	X waiver	X w/in res support	X C waiver	X	X SLS waiver & State plan	X waiver	X	X
Supported Employment	X	X (long term thru Med.)	X	X	X (also has self-employment)	X	X	X	X	X
Transportation	X	X State plan	X		X C waiver	X	X	Looks like no	X	X

Other services offered not specific to DD - Adult foster Care - Idaho
Residential assisted living (A&D waiver) – Idaho and Arizona
Home Health Aid – Arizona
Hospice – Arizona

Supports and Services **Not** Offered in Idaho – pg 3

Current Services	Idaho 1915i	Michigan 1915 b/c <small>School age 26</small>	Arizona 1115, 1915K PCS-self dir.	Rhode Island 1115 Has wait list	New Mexico 1915i & 1915c Has wait list	New York 1915 b/c?	Colorado 1915c	Wyoming Has Wait list 2-3 yrs	Oregon	North Carolina 1915 b/c
Adult Ed. Supports						X				
Attendant Care			X							
Day Treatment for MI		X <small>State plan</small>								
Elderly DD targeted services						X				
Family Training		X <small>State plan</small>					X		X	
Homemaker			X	X			X <small>SLS waiver</small>	X <small>waiver</small>	X	
IBI for Autistics						X				
IRA Homes (up to 14)						X				
Mentorship							X			
Nutrition					X			X		
Counseling										
Residential for Non-waiver	Not sure which	State offers this								
Risk Screening for Inapp. Behaviors					X				X	
Socialization					X				X	
Sexuality										
Therapeutic recreation							X			

Note – other states allow individuals using the Self-Directed Waiver to purchase services from providers Idaho restricts this

North Carolina also offers: Assistive Technology Equipment and Supplies, Natural Supports Education, Vehicle Modifications and Specialized Consultation Services (i.e. Tele Consultation)

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APPENDIX C: ARIZONA STUDY SUMMARY

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**Arizona Fact-Finding Trip Report
to
Idaho's Collaborative Workgroup (CWG) on Services for Adults with
Developmental Disabilities
July 24, 2014**

CWG Arizona Fact-Finding Trip Report

In May 2014, a group of stakeholders from Idaho's Collaborative Workgroup (CWG) on Services for Adults with Developmental Disabilities visited Arizona to investigate their DD service delivery system. The stakeholders who visited Arizona included Christine Pisani, Bill Benkula, Art Evans, and Matthew Wappett. This trip included visits with state employees, policymakers, self-advocates, and families. This report outlines some of the key findings from this investigatory trip and provides backup documentation as an additional resource for consideration by the entire CWG.

Background

Arizona was one of the first states to create a comprehensive system for people with developmental disabilities committed to serving everyone eligible through an 1115 Medicaid Waiver (NASDDDS, 2010). Arizona has created a highly cost effective service system by moving away from large congregate settings and supporting individuals living with their families or in small community residences. As a result, Arizona is one of the most cost effective programs in the country, with only one state in the nation spending less per capita (NASDDDS, 2010). *The Case for Inclusion 2014* report put out by United Cerebral Palsy (UCP) ranked Arizona's Medicaid system for serving individuals with intellectual and developmental disabilities as #1 in the nation (UCP, 2014).

The Arizona Long Term Care System (ALTCS) serves over 34,970 people with developmental disabilities (AHCCCS, 2014). There has been steady growth in the program: from FY 2005 through FY 2013, enrollment in the DD program increased from 15,937 to 34,970 or 119.4%; of this amount approximately 26,000 receive long term care services, the other 8,900 individuals, who do not meet ALTCS eligibility, are served through a developmental disability "state only" funded program. This "state only" program provides for support coordination services and focuses on helping individuals find resources and natural supports in their communities. The annual budget for the ALTCS and "state only" program is approximately \$900 million.

Trip Agenda & Data Sources

Data that inform this report were derived from multiple conversations with stakeholders in Arizona. The data was primarily qualitative and taken from transcripts (see attached), notes, and personal recall by the participants on the fact-finding trip.

The agenda for the visits conducted on the Arizona trip was as follows:

Thursday, May 1, 2014

10:30 am Meeting with staff from Arizona Health Care Cost

Containment System and the Division of Developmental Disabilities
12:15 pm Lunch with Arizona DD Council Staff and Council Members
2:30 pm Raising Special Kids - Parent meeting to discuss the AZ managed care model

Friday, May 2, 2014

10:00 am Jon Meyers, Executive Director, The ARC of Arizona
11:00 am Health & Wellness Fair - Disability Empowerment Center
1:00 pm Meeting with participants of the service system
3:30 pm Gompers Habilitation Center

General Findings and Observations

The AZ system has achieved much of their success through an 1115 R&D waiver (as opposed to a 1915(c) waiver, like Idaho). This allows them much more flexibility and leeway in how they manage their systems, define their cost methodology, and conduct quality assurance. The 1115 R&D waiver requires more reporting and oversight from CMS, but in the long run it has allowed Arizona to serve more people with disabilities in a more efficient manner. Much of what Arizona has accomplished would be difficult, and in some cases impossible, under a 1915(c) waiver.

AZ has a one-time assessment and qualification process. When an individual qualifies for the ALTCS program they do not have to go through annual reassessments or qualification processes. Arizona currently uses a person-centered planning model facilitated by care coordinators to identify individuals needs and to determine necessary services. Nevertheless, they are currently conducting a proof of concept pilot with the SIS this summer and are in contract talks with Arizona's two UCEDDs to take on the task of conducting annual assessments for ALTCS clients using the SIS. They are currently unsure of how the SIS assessment process would affect the budgeting process for clients.

Because they operate under an 1115 waiver AZ uses an individual cost neutrality model as opposed to an aggregate cost neutrality model like Idaho. Each client's needs and ISP is reviewed by AHCCS (the fiscal side of ALTCS) through a Cost Effectiveness Study (CES) to ensure that the costs for each person receiving services in the community does not exceed an institutional threshold for costs. The department reported that most adults with disabilities who qualify for the ALTCS program are living with their parents/families, which helps to keep costs contained. Arizona's narrow definition used for ALTCS eligibility also helps keep costs contained.

Another mechanism that Arizona uses for cost containment is the use of "shared risk agreements" with individuals with disabilities and their families. Arizona will rarely provide 24-hour monitoring or support services for individuals with significant medical conditions, even if a medical professional or the family feels that those services are necessary. ALTCS, through the care coordinator, will

negotiate an arrangement with the family where they will compromise on a “reasonable” amount of support and will then ask the family to assume the risk of monitoring the other times. For example, the state may provide for 12 hours a day of monitoring/support for an individual on a ventilator who requires constant adjustment and suction to keep the ventilator clear, and then Medicaid will ask the family to provide that support for the other 12 hours. The families sign a “shared risk agreement” that releases the state from liability for the time that the family is providing the support. Arizona Medicaid also uses these shared risk agreements for individuals who want to self-direct their own services or who want to live independently in the community. In the event there is no way to assure safety under the shared risk agreements model, and the individual requires 24 hour supports, Arizona does have several 6 to 8 bed group homes that are available but they are not licensed as ICF/IDs.

ALTCS clients have the ability to self-direct their services within a set of programmatic constraints. Clients can hire and fire staff through the use of a fiscal intermediary, but they are unable to pay them as they wish because all service rates are set by the state and cannot exceed institutional rates to ensure individual cost neutrality. As mentioned earlier, ALTCS will also use shared risk agreements to provide additional flexibility for clients who want to pursue activities and/or living arrangements that are not wholly supported through Medicaid. Medicaid contracts with an independent living center to provide extensive training called “This is My Life” to individuals with developmental disabilities. The training addresses the importance of speaking up, how to speak up, the service system, and many other topics related to controlling one’s services and quality of life (see: <http://www.abil.org/this-is-my-life/>).

High quality care coordination/support brokerage is a linchpin to the success of the ALTCS system. State staff, advocacy organization personnel, parents, and self-advocates all commented on the importance of high quality care coordination in the ALTCS system. Care coordination is delivered directly by the State (i.e. care coordinators are State employees) and there is a strong focus on identifying and leveraging natural supports before bringing in paid supports. Care coordinators receive extensive and ongoing training from the Arizona Division on Developmental Disabilities (ADDD), and are constantly being monitored and evaluated by the ADDD (see attached ADDD Training Planning and Tracking Form for Support Coordinators). Care coordinators typically have caseloads of 50-60 clients.

Consumer satisfaction appears to be high for individuals who are in the system; although we did learn that it can be difficult for some individuals to get into the ALTCS system. This was evidenced by the fact that there are many legal firms that specialize in helping clients qualify for ALTCS. Self-advocates whom we spoke with informed us that it is NOT necessary to have attorneys assist when applying for services, but that many people are denied services because Arizona uses such a narrow definition for eligibility. Legal firms typically become

involved after people have been denied access; legal firms help individuals appeal their case, and provide assistance in arguing that the individuals does, in fact, meet the eligibility criteria and should be allowed access to the services available. For example Teresa Moore, a national self-advocate whom we met with, had no trouble applying for and accessing the ALTCS program, but her friend that also met with us, was denied access because he sustained his spinal cord injury in a car accident at age 16.

It became clear from our conversations that ALTCS and the State of Arizona were deeply committed to creating functional partnerships between the state agencies, advocacy organization, and provider groups. In addition to contracting with independent living centers to provide self-advocacy training, Arizona Medicaid also contracts with the Arizona Parent Training Center to provide parent training to learn about the service system, how to navigate the service system, and provides the ability to have parents involved in systems change and public policy discussions directly related to the service system. This center is also directly involved in the development of the training curriculum and the actual training of the care coordinators. Rates for providers are kept current by a very specific methodology of reviewing rates annually and doing a mandatory re-basing of rates every 5 years. Arizona uses the same method of setting rates as Idaho has in statute but in Idaho that method has never fully been implemented.

Guardianship appears to be encouraged within Arizona and there are self-service centers available to download all of the forms necessary to file for guardianship. This was a clear theme through our discussions with the state and with parents.

AZ places a high priority of data and specifically in their participation in the National Core Indicators project. The National Core indicators data provides robust data that helps them gauge their effectiveness and it assists the State in being proactive in planning for future needs. Although participating in the NCI did place an additional administrative burden on the State, the benefits far outweigh the costs of participation according to ALTCS personnel.

All of the people we met with mentioned that Arizona's service system was very urban-centric and that people residing in rural and remote areas (anywhere outside of the Phoenix/Scottsdale or Tucson areas) have limited access to quality services. Several people mentioned having to move closer to urban areas to receive the services and supports they needed.

Arizona has the largest American Indian population of any other state. Most of the tribal groups are located in the "Four Corners" area in the north of the state, although there are several large tribal groups located in the Phoenix area. All of the parties we spoke with mentioned the challenges inherent in delivering services to this rural population. We did learn that the "Four Corners" region has its' own protection and advocacy organization to assist tribal members in accessing services.

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<http://www.icdd.idaho.gov/projects/Adult%20Services/ASR.html>

2014 Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities: Findings and Initiatives

JANUARY 27, 2015



2014 Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities” Findings and Initiatives

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Executive Summary

2014 Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities: Findings and Initiatives January 27, 2015

Vision

The Collaborative Work Group (CWG) on Adult Developmental Disability (DD) Services represents a range of people with developmental disabilities, service providers, advocates, agencies and policymakers. This group has convened to constructively influence the development of Idaho's adult DD service system consistent with the following vision:

By 2020, adults with developmental disabilities living in Idaho enjoy the same opportunities, freedoms and rights as their neighbors. They have access to sustainable service systems that provide quality, individualized supports to meet their lifelong and changing needs, interests and choices.

Core Question

Given the unique and diverse needs of adults with developmental disabilities, the paid and unpaid, public and private nature of the system, and the finite resources available through Medicaid, the CWG seeks to design the system so it provides optimum supports and opportunity for productive living.

Findings

1. Idaho's self-direction option provides for a wide array of services, contingencies and choices
2. Employment is an important and desirable outcome for most people with DD
3. An opportunity exists to improve Idaho's assessment and resource allocation process
4. A managed care organization model is designed for medical care; it would be difficult to develop a managed care organization to appropriately serve the DD population

2015 Initiatives

1. Collaborate on Home and Community Based Services Rules Implementation
2. Revise the current assessment and resource allocation system to ensure that resources are matched to actual individual needs and aligned with the person centered planning process
3. Enroll Idaho as a participant in the National Core Indicators Project (<http://www.nationalcoreindicators.org>)
4. Generate a solid infrastructure, in coordination with University of Idaho's Center on Disabilities and Human Development, that provides the adult DD population an active, consistent and effective voice in systems change

Introduction

Respect

The Collaborative Work Group (CWG) on Adult Developmental Disability (DD) Services is a group of individuals who have come together to constructively influence the development of Idaho's adult DD service system. Convened by the Idaho Council on Developmental Disabilities (ICDD) in November 2011, the group aspires to achieve the following vision:

By 2020, adults with developmental disabilities living in Idaho enjoy the same opportunities, freedoms and rights as their neighbors. They have access to sustainable service systems that provide quality, individualized supports to meet their lifelong and changing needs, interests and choices.

The CWG represents a range of people with developmental disabilities, service providers, advocates, state agencies and policymakers. It features an eight-member steering committee that meets monthly to do the detailed work. The steering committee presents its work to the full membership of the CWG for feedback and approval at least three times a year.

CWG seeks to influence the entire system, the core of which are Medicaid-paid services, as well as other important community and natural supports, paid and unpaid, such as employment, housing and transportation—supports essential to helping adults with developmental disabilities live meaningfully inclusive and productive lives.

CWG acknowledges and cautions that any changes to any part of the system recognize the impact of that change among other services, supports, systems and lives.

In its nearly 3 years of functioning, the CWG has undertaken the following scope of work, producing deliverables in most cases discussed in more detail later in this report. The CWG has

- Surveyed providers and people with disabilities to determine what is working and not working in the current system, generating a Checklist (See Attachment A) of qualities to feature in any proposed changes to the system
- Researched other states and compared respective assessment, service array and budgeting processes, detailed in a summary document (see Attachment B)
- Worked on and helped pass legislation for supported employment
- Visited and generated a corresponding report about the State of Arizona's system, where some CWG members met with state personnel, providers and adults with developmental disabilities to understand the nuances of that system in order to inform ideas about MCO functionality (see Attachment C)
- Generated a list of findings and features under development for the future system as presented in this document—the CWG's 2014 Report: Findings and Initiatives (Report)

- Initiated a more thorough examination and use of the existing Self Direction program to promote the opportunity and flexibility the existing program offers
- Initiated a study of needs assessment processes to ensure the best assignment of services and most appropriate allocation of financial resources

The findings and initiatives presented in this Report focus primarily on Idaho's Division of Medicaid (Medicaid) and support efforts undertaken by the Employment First Consortium. In addition to completing the more robust implementation of the Self Direction program and investigating effective and efficient improvements to the existing needs assessment process, in 2015 the CWG will look at the status, needs and opportunities related to the non-Medicaid aspects of the system—the community and natural supports so integral for living healthy and productive lives.

Always, the CWG work and recommendations are grounded in the following values:

- Respect
- Safety
- Choice
- Quality
- Community Inclusion

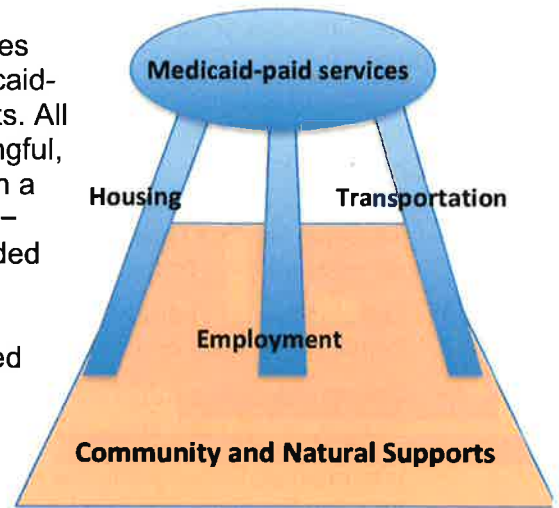
More information about the CWG, including an introductory video and group products, can be found on the ICDD website, at: <http://www.icdd.idaho.gov/projects/Adult%20Services/ASR.html>

Table 1: CWG Membership

CWG Members	Delegate	Alternate
ACCESS Idaho	Trinity Nicholson**	Lisa Cahill
Idaho Assoc. of Developmental Disability Agencies	Maureen Stokes**	Corey Makizuru
Case Management Assoc. of Idaho	Joanne Anderson	None
Care Providers Network of Idaho (CFHs)	Eva Blecha	Becky Solders
Center on Disabilities and Human Development, UI	Julie Fodor, PhD	Richelle Tierney**
Division of Medicaid	Art Evans**	Jean Christensen*
Disability Rights Idaho	Jim Baugh**	Dina Brewer
Council on Developmental Disabilities	Christine Pisani **	Tracy Warren
Vocational Rehabilitation	Jane Donnellan	None
Self Advocate Leadership Network	Noll Garcia*	Kristyn Herbert*
Residential Supported Living Assoc.	Bill Benkula **	None
Division of Family & Community Services (crisis)	Oscar Morgan	None
Vocational Services of Idaho	Kelly Keele**	Cassie Mills
Idaho Health Assoc./ICFs-ID	Tom Moss	Kris Ellis
LINC/Centers for Independent Living	Roger Howard	None
Office of the Governor	Tammy Perkins	None
Legislature	Rep. Sue Chew*	None
Legislature	Sen. Lee Heider	None

The Current Service System

The service system for adults with disabilities features an important combination of Medicaid-paid services and other community supports. All are required to enable adults to live meaningful, productive lives. Like a stool with its legs on a foundation—a range of community supports—Medicaid pays for many core services needed for eligible adults; however other non-Medicaid supports, such as housing, employment and transportation, are required to enable living as independently as possible. Without one key community support, other supports become more intensive and quality of life diminishes.



Developmental Disabilities – Idaho's Definition

The Section 66-402(5) Idaho Code defines a developmental disability as:

A chronic disability of a person that appears before 22 years of age and is

- Attributable to impairment such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments.

The condition:

- Results in substantial functional limitations in three or more of the following areas of life activity: self-care, receptive and expressive language, learning, mobility self-direction, capacity for independent living, or economic self-sufficiency;
- Reflects the needs for a combination and sequence of special interdisciplinary or generic care, treatment or other services, which are of life-long or extended duration and individually planned and coordinated.

Services for Adults with Developmental Disabilities – An Overview

Medicaid Services

Medicaid is a federal program with a roughly 70/30 federal to state match providing funding for medical and health related services for people with low income in the United States. The Bureau of Developmental Disabilities Services (BDDS) within the Idaho Department of Health and Welfare Division of Medicaid manages the Medicaid-paid services for adults with developmental disabilities.

In Idaho, adults with developmental disabilities may be eligible for Medicaid benefits. Adults can apply for those benefits through an Idaho Department of Health and Welfare Independent Assessment Providers in a process that takes only a couple of hours. Eligibility is determined within a couple months.

The following services and supports are available for adults with developmental disabilities through Idaho Medicaid:

- Targeted Service Coordination—a service for individuals who cannot access, coordinate or maintain services on their own
- Developmental Therapy—skill development services provided through individual or group therapy in the home, community or a center
- Community Crisis Supports—interventions for individuals who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies
- Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) Services—an ICF/ID is a home for up to 8 individuals. The home has shared dining, living and cooking areas. Each individual can have a private bedroom or share a bedroom with another individual. Services provided by the ICF/ID are designed to meet the needs of individuals requiring in-home care, and provide services 24 hours a day

Through a Medicaid Waiver program (Medicaid Home and Community-Based Services §1915(c) of the Social Security Act), Medicaid provides each state the opportunity to provide an array of services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. States have broad discretion in designing the waiver program to best complement traditional Medicaid services, meet the needs of the state's population in a manner that is cost-effective, and employ a variety of service delivery approaches, including participant direction of services.¹ Medicaid Home and Community-Based Services Rules have been revised in 2014, providing even more flexibility, assurances and choice for the participant.

Idaho's Division of Medicaid has worked with intentionality to develop a quality waiver program, which features the following DD Waiver services:²

- Residential Habilitation—Certified Family Home and/or Supporting Living
 - Certified Family Home: an individual can live in the home of his/her parents, the home of another family member, or the home of someone in the community who is not related. Some supports and services will be provided in the home and some supports and services will be provided in the community.
 - Supporting Living Services: an individual can live in his/her own home, apartment, or an apartment with up to two other individuals. Supports and services can be provided in the home or apartment and in the community to help the individual live as independently as possible.
- Chore Services—might include washing windows, moving heavy furniture, or shoveling snow.

¹ <http://www.healthandwelfare.idaho.gov/Portals/0/Medical/DD%20Waiver.pdf>

² <http://www.healthandwelfare.idaho.gov/Portals/0/Medical/DevelopmentalDisabilities/Medicaid%20Services%20and%20Supports.pdf>

- Respite Services—services provided on a short-term basis due to the absence of the normal caregiver, and limited to the individual who lives with non-paid caregivers
- Supported Employment—provides support in a competitive work setting with job coaches who help the individual learn the job.
- Non-medical transportation—transportation to community services.
- Environmental Accessibility Adaptations—provides for certain interior and exterior changes to the home, which enable individuals who would otherwise be institutionalized to function with greater independence in the home.
- Specialized Medical Equipment and Supplies—additional supports when the state plan limits are used up, or the equipment or supply is not available under the regular state plan. Items must be necessary for the direct medical or remedial benefit of the individual.
- Personal Emergency Response Systems (PERS) A PERS unit is a portable or stationary device that is used to call for help in an emergency. This item is sometimes referred to as a “lifeline.”
- Home Delivered Meals—a service that delivers one or two nutritious meals each day for individuals who are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who are unable to prepare a meals without assistance.
- Skilled Nursing—Provides professional nursing services to individuals who need them. Nursing services must be recommended by a physician and must be listed on the participant’s plan.
- Behavioral Management and Crisis Management—This service is delivered to individuals who are having a psychological, behavioral or emotional crisis. Behavioral and crisis management is an emergency back up and provides direct support for the individual in crisis.
- Adult Day Health—a supervised and structured day program for individuals to receive a variety of social, recreational and health activities.
- Self-Directed Community supports—this is a Medicaid option for adults who are eligible for the DD waiver. This option provides participants the opportunity to make their own choices about supports, giving them freedom to manage their own lives. Participants do not have to choose supports alone. They have as much or as little help as they need from a support broker, a circle of support, and a fiscal employer agent (FEA).
 - Participants will have an individualized budget, create a support and spending plan, hire workers, and buy goods and services. Participants must agree to follow four guiding principles:
 - Freedom to plan their own lives
 - Control over their Medicaid dollars to buy supports and services
 - Support to become involved in their communities
 - Responsibility for their choices and decisions
 - If self-direction does not work, individuals can go back to receiving traditional Medicaid DD services.

Currently, approximately 3500 adults receive Medicaid waiver services in Idaho, served by approximately 100 Medicaid Providers. The services provided in Idaho are found to be more extensive than those provided in other states the CWG researched.

Community and Natural Supports

Any individual has a range of needs specific to their condition and community that must be met in order to live as independently and meaningfully as possible in their own community. CWG has identified the following list of essential needs:

- a. Food and Housing
- b. Health Care
- c. Safety
- d. Employment
- e. Development of Independent Living Skills
- f. Mental and Behavioral Health
- g. Integration in Community Activities
- h. Transportation
- i. Protection of Rights and Self Determination

Clearly, some of these needs can be met through Medicaid services but many of them cannot. Putting all these pieces together for a single individual in a specific location requires attentive planning and meaningful individual, family, agency, and community engagement.

The CWG defines community supports as those resources in the community needed by the individual to help them live their lives as fully as possible – those needs beyond what Medicaid can provide, but which may be paid or non-paid, provided by agencies and entities other than Health and Welfare (Housing, Vocational Education, Transportation, communities, families), and which complete the individual's system of care.

Work undertaken and anticipated by the CWG around community supports, specifically employment and housing, are discussed in more detail in future chapters of this report.

Core Question

Given finite resources available through Medicaid, and the unique and diverse needs of the adult DD population, the underlying question the CWG needs to address is how to design the system so it provides optimum supports and opportunity for productive living.

Research

choice

To inform its understanding of DD system options and possibilities, the CWG studied the following 11 states:

- Arizona
- Colorado
- Florida
- Michigan
- New Mexico
- New York
- North Carolina
- Ohio
- Oregon
- Rhode Island
- Wyoming

Research involved reviewing the individual states' websites, and interviewing Directors, state Developmental Disabilities Councils, and state agency personnel.

Summarily, CWG learned many states authorize their services regionally instead of statewide, sometimes resulting in different rates and services in different regions of the state. Other states have long waiting lists. One common element was identified in many of the states CWG explored is using the Supports Intensity Scale (SIS) as the tool to establish budgets for adults with Intellectual and Developmental Disabilities. The National Office of United Cerebral Palsy has rated Arizona number one in the nation for service delivery for people who experience intellectual disabilities and developmental disabilities.

Arizona's system featured some components that warranted additional research, including functioning as a state-managed care organization (MCO), no wait lists, a responsive reimbursement methodology, and a heralded partnership between the state agencies, advocacy and provider groups.

In Arizona, state employees function as service coordinators and participate in individual Person-Centered-Planning³ meetings and plan development. The Arizona Department of Economic Security (equivalent to Idaho's Department of Health & Welfare) contracts with Raising Special Kids, the Arizona Parent Training Center, to conduct and oversee coordinator training. Extensive training is provided on a range of topics including education about how to develop unpaid supports, and how to help adults and families develop those supports where they may be limited or not currently in place.

One downfall in Arizona is that Arizona does not have a 1915(c) waiver – they operate an 1115 demonstration waiver. People who qualify for the 1115 must function on an individual cost neutrality. Individual cost neutrality means if they cannot pay for the supports they need for 24-hour care in their own home with

³ Person Centered Planning is an ongoing problem-solving process used to help people with disabilities plan for their future. In person centered planning, groups of people focus on an individual and that person's vision of what they would like to do in the future.

the funds they are provided, they must either have natural supports willing to sign a risk agreement with the state or they must live in a 6-8 bed group home. However, family members of children living in these group homes express satisfaction with the supports and services their loved ones receive.

Appendix B provides a summary of the states reviewed and description of how those systems work. Appendix C describes in more detail the findings of CWG study of Arizona's MCO-operated program, which had direct bearing on future considerations for Idaho's program presented in the next section.

Findings

Supports and services for people with developmental disabilities are most effective when they are flexible, adaptive and conform to the natural flow of the participant's needs, life and choices.

To provide appropriate supports for the DD community, a system of care must be broad and flexible, addressing an individual's needs for:

1. Food and Housing
2. Health Care
3. Safety
4. Employment
5. Development of Independent Living Skills
6. Mental and Behavioral Health
7. Integration in Community Activities
8. Transportation
9. Protection of Rights and Self Determination

Medicaid plays a leading role in providing health care, independent living skills and mental and behavioral health. Medicaid also has a role in providing for safety, employment, community integration, and transportation along with other state agencies and community supports. Food and housing are not part of the Medicaid program, except for people in long-term care facilities. People with developmental disabilities need help with obtaining and coordinating assistance from Medicaid and non-Medicaid service providers.

A good system of care will support as precisely as possible the approved services to meet an individual's unique needs, with reimbursement rates to match the actual cost of providing the service.

Findings

Federal Medicaid regulations can create challenges to flexibility and adaptability of services

Most Medicaid Services are specifically defined. Services are provided by people with specific qualifications employed by certified provider organizations. Services come in units, usually specific blocks of time. Each service has a specific reimbursement rate and billing code. These are features of a medical model of reimbursement for procedures and office visits. The CWG recognizes service definitions and rate setting create strong incentives and disincentives, and CWG seeks to be aware of the incentives it creates.

Life does not take place in defined time blocks. Life happens all of the time everywhere you go and whomever you are with. Life requires a kind of free flowing, constantly adapting, creative responsiveness. This is often incompatible with the discreet units of precisely defined billing codes, or "services".

Acknowledging this reality and addressing it to the extent possible in the design of the system is key to the CWG Vision for adults with developmental disabilities.

Idaho's self-direction option provides for a wide array of services, contingencies and choices

Idaho's "My Voice My Choice" (MVMC) self-directed (waiver) option makes possible a high level of participant choice, control and flexibility within the Medicaid system. It can be creatively adapted to a participant's needs and choices. It is possible to use the MVMC option to access services from traditional providers in a way that preserves choice and flexibility. This option currently serves 574 adults and has experienced steady growth.

In order to leverage those opportunities, CWG has, in partnership with the Division of Medicaid, embarked on an effort to generate a greater understanding of the opportunities the self-directed option affords by engaging participants and providers in the process of testing those opportunities, then measuring and reporting on outcomes in response. The CWG has undertaken a number of surveys to learn about levels of satisfaction with the self-directed option. Preliminary results indicate an opportunity to provide some education to dispel some of the myths and misinformation about who can access and how to access self-direction, as well as who may provide services within the option.

Employment is an important and desirable outcome for most people with DD

The Collaborative Work group endorses the efforts of Employment First Consortium, another group convened by the ICDD for the purpose of improving how employment services and systems work in Idaho so people with DD are able to reach their career goals. The Consortium provided specific employment service definitions and system improvement recommendations to inform the work of the CWG.

The CWG reviewed and supported legislation proposed by a collaborative workgroup including both CWG and Consortium members. The law was passed by the 2014 State Legislature and allows individuals to request additional service plan dollars for community supported employment services. One result of this statute change is that more people who are eligible for the DD waiver are able to include long-term employment support services under Medicaid in their service plan. This enables them to access vocational rehabilitation services rather than be added to the waitlist for the extended employment services program.

Employment provides individuals with developmental disabilities the opportunity to be an active participant in their community and to: build relationships, increase their social capital, improve their overall health, and become economically self-sufficient. Having a job has a positive effect on overall quality of life.

An opportunity exists to improve Idaho's assessment and resource allocation process

CWG purports assessments should:

- Provide information to establish eligibility for DD services and for waivers

- Determine the needs of participants and the amount and types of services that can meet those needs utilizing a person centered planning process
- Allocate resources consistent with the participant's needed support level

Idaho currently uses the Scales of Independent Behavior – Revised (SIB-R), which has not been updated or re-normed for a long time. There is some indication the SIB-R may be re-normed in the future, but there is no indication of when or whether it will be updated for use on current software systems.

There is also some dissatisfaction with how the SIB-R is implemented and the consistency and thoroughness of its use. Furthermore, adults with developmental disabilities and families have expressed frustration with the SIB-R's deficit based approach as opposed to using a strength-based approach consistent with current principles around best practice.

CWG is investigating the use of other methods of assessing the need for services and matching needs to resources including the InterRAI, Arizona's assessment /planning process, the Supports Intensity Scale (SIS) and others. While the SIS is better than the SIB-R in that it actually asks about services and supports the participant needs, instead of merely about their skills. However, it still assigns numbers to responses and yields a final overall supports score. Any evaluation that reduces the information about service needs to a single number (or 2 or 3 numbers) retains some of the objectionable features of the SIB-R.

InterRAI, however, continues to be a tool of high interest to the CWG. Work is underway to further understand its features. CWG envisions an opportunity to conduct an assessment resulting in an individual's need for resources based on an objective individual determination, rather than a score or a correlation. This will allow participants' broad flexibility and opportunity to make the best use of the resources to meet participant needs. While the CWG continues to study InterRAI, the DHW Division of Medicaid has committed staff resources to research and test assessment and resource allocation models, working actively with CWG to find the best statewide solution.

In addressing needs, "Natural Supports," or unpaid sources of assistance, may provide needed support and community integration for people with DD while reducing dependence on government financed services. Because "natural supports" are voluntary, they often are not predictable or reliable. CWG finds natural supports an underdeveloped resource in Idaho. However, the state does pay for support provided by family members, which may actually undermine the concept of natural supports. The issue and the resource warrant study and development.

A managed care organization model is designed for medical care; it would be difficult to develop a capitated managed care organization to appropriately serve the DD population.

A managed care organization (MCO) combines the functions of health insurance, delivery of care, and administration in a single organization. Typically, MCOs (such as health insurance companies) have considerable experience with medical care management. Medical managed care strategies rely on preventive treatment and care management to realize savings by reducing more expensive surgical and in-patient treatments.

DD services are very different from medical treatments and procedures. There is no reason to expect that the disability will be “cured” or that the participant will be rehabilitated to the level of complete independent functioning. DD services provide long-term supports for activities throughout the participant’s day and life span. Unlike medical procedures and therapies, DD services are not generally delivered in clinical settings and are most effective when they are integrated into home and community activities. DD services emphasize skill-building, adaptation, and supportive assistance rather than surgery, medication, and symptom control. Furthermore, federal requirements (and best practices) for individualized “person centered planning” and the ongoing supportive nature of DD services challenge the suitability of medical managed care models.

A couple states are experimenting with an MCO model in which a state agency (such as the Division of Developmental Disabilities) acts as an MCO. However, they must overcome the reality of the financial incentives built into MCO models, where a “per member per month” (PMPM) payment system may encourage the reduction of services without any incentives for improved outcomes. Idaho Medicaid services for people with DD already employ managed care strategies including prior authorizations, comprehensive services plans, care coordination, independent assessments, and individual service budgets. Some services, such as supported living and certified family homes, are already structured as capitated daily rates for comprehensive supports. The MCO feature Idaho has not adopted is a single capitated rate for the entire population. This is specifically because of the wide variations within the DD population. Some capitation features, including the limits on the total funding available in individual budgets, are featured in Idaho’s system. A high level of quality assurance is important for any DD service system, but it is even more important for managed care models.

In order to ensure Idaho’s funding is most appropriately budgeted for each individual, CWG finds that deploying a more effective assessment and resource allocation process will secure better outcomes than a capitated MCO contract structure.

2015 Initiatives

Community Inclusion

Collaborate on Home and Community Based Services Rules Implementation

In January 2014, the Center for Medicare and Medicaid Services (CMS) passed new final rules for the use of home and community-based Medicaid funding. The rule enhances quality, adds protections for individuals receiving services, ensures individuals have full access to the benefits of community living, are able to receive services in the most integrated setting, defines person-centered planning requirements, and provides for additional compliance options for waiver programs.⁴

Idaho's Division of Medicaid has already conducted a Gap Analysis and issued a Transition Plan for residential services to work toward the requirement of the new rules. The National Association of Councils on Developmental Disabilities has acknowledged Idaho for having produced one of, if not the most, responsive draft transition plans among the states.

Idaho also recently released the draft Transitional Plan for Non-residential settings.

Idaho is also fortunate in that it has an already established group—the CWG—to collaborate with the Division to implement the rules over the next five years. The CWG's vision for adults with DD is generally consistent with the new rules. The HCBS rules provide a framework for important parts of the DD system with which Idaho must comply. The CWG must ensure that the enhancements it proposes to the system are in compliance with these federal rules.

As the CMS HCBS rules are implemented, the Division of Medicaid is providing monthly updates to the CWG Steering committee on the status of transition planning and outreach to stakeholders. To ensure adults with developmental disabilities have a real voice in the implementation of the rules and reflect the actual impact, CWG members from the Council on Developmental Disabilities (ICDD), the Center on Disabilities and Human Development (CDHD), and Medicaid are working collaboratively to create a survey and conduct statewide focus groups with adults with developmental disabilities and families.

In addition to the statewide focus groups, ICDD and the CDHD are creating a statewide study of adults with significant disabilities to learn of their experiences with the implementation of the HCBS rules. The results of this study, along with information collected through the focus groups, will provide a wealth of information from people served by the developmental disabilities waiver. This baseline of information will then be provided to the Division of Medicaid for its

⁴ <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-01-10-2.html>

use in evaluating service provider compliance within the first year of HCBS rules implementation and in future years.

Revise the current assessment/resource allocation system to ensure that resources are effectively matched to actual individual needs and are aligned with the person centered planning process.

Much of CWG's current effort is in the study of needs assessment options and of interRAI specifically. CWG will continue to pursue this opportunity through 2015.

Enroll Idaho as a participant in the National Core Indicators Project™⁵

The National Core Indicators™ (NCI) is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. Core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice and health and safety. Forty-two states have joined and are able to compare outcomes against each other's data. States participants report the acquisition of data that allows them to project future needs, trends, and where a state system may have a shortfall of available services to meet a growing demand.

The following table identifies the core indicators and what each addresses:

Core Indicator	Address
Individual Outcomes	How well the public system aids adults with developmental disabilities to work, participate in their communities, have friends and sustain relationships, and exercise choice and self-determination. Other indicators in this domain probe how satisfied individuals are with services and supports.
Health, Welfare and Rights	(a) Safety and personal security (b) Health and wellness (c) Protection of and respect for individual rights
System Performance	(a) Service coordination (b) Family and individual participation in provider-level decisions (c) The utilization of and outlays for various types of services and supports (d) Cultural competency (e) Access to services.
Staff Stability	Provider staff stability and competence of direct contact staff.
Family Indicators	How well the public system assists children and adults with developmental disabilities, and their families, to exercise choice and control in their decision-making, participate in their communities, and maintain family relationships. Additional indicators probe how satisfied families are with services and supports they receive, and how supports have affected their lives.

Table 2: National Core Indicators

⁵ <http://www.nationalcoreindicators.org/>

Idaho is one of thirteen states that have not joined NCI. With an acknowledged participation fee and need for Idaho staff resources, the CWG still finds participation in the NCI would prove advantageous to the state.

Generate a solid infrastructure, in coordination with University of Idaho's Center on Disabilities and Human Development (CDHD), providing the adult DD population an active, and effective voice in systems change

One of CWG's initiatives was to pursue a meaningful and consistent way to engage the adult DD population throughout the state and at all levels of functionality in systems change. CWG considers it essential for people with developmental disabilities are at the core of shaping their new service delivery system. While people with developmental disabilities have been involved throughout the work of the CWG, it was strongly felt that there was a need to be doing more to get a broader and deeper range of feedback from adults with developmental disabilities across the state.

Thanks to the leadership and expertise offered through CDHD, an important link through the policy, advocate and service levels of the DD population is being established.

CDHD houses the Coordinator for its own CDHD Community Advocacy Committee (CAC). The CAC's mission is to guide CDHD leaders by "providing insight into the opportunities and challenges facing people with disabilities and their families on national, state and local levels." The same person who holds the position as Coordinator for the CAC is also the state coordinator for the Idaho Self-Advocate Leadership Network (SALN). SALN is Idaho's statewide self-advocacy organization led by and for adults with developmental disabilities. SALN receives funds through a contract with the DD Council. SALN consists of a network of local chapters in Moscow, Nampa, Boise, Pocatello and Idaho Falls. Self-advocates participate in statewide and national self-advocacy education and participate on task forces developing state and national public policy. Members provide valuable insight into the lives of adults with developmental disabilities.

To help fulfill the objective for participant voices in CWG efforts, the CAC/SALN Coordinator now participates on the CWG Steering Committee. In that role, the Coordinator will use existing structures and processes to consistently engage adults with developmental disabilities in discussions about issues and ideas from the CWG. The process will capture opinions of adults with varying disabilities and from diverse geographical areas of the state.

The following lists additional initiatives CWG will pursue in 2015:

1. Create incentives for desired outcomes as opposed to units of service, and develop objective criteria and participant satisfaction measures to drive a robust quality assurance program.
2. Avoid administrative burdens created by compartmentalizing daily activities into multiple discreet billing codes and service definitions, to the extent allowed by federal Medicaid regulations.
3. Expand the use of current Medicaid models which allow for flexible and responsive supports such as the "My Voice, My Choice" (MVMC) option and Supported Living services.

4. Remove barriers and disincentives to using MVMC to access services from traditional service providers, and encourage systems that allow providers to offer service packages to participants.
5. Adopt an “Employment First” approach to services, encouraging employment to be considered in each person’s planning process and incentivizing employment outcomes for people with DD.
6. Explore the opportunity for Medicaid to contract with Independent Living Centers to provide training to participants on navigating the service system, managing their own services, avoiding abuse and exploitation, and selecting providers.
7. Explore the opportunity for Medicaid to contract with Idaho Parents Unlimited (IPUL) to train parents and family members on selecting and managing services and supports.
8. Explore the opportunity for Medicaid to conduct frequent (annual if possible) review of provider rates and costs.
9. Explore how Medicaid may be able to increase the available training for providers.

CWG efforts will continue to seek increased flexibility and responsiveness in a manner integrated into the natural flow of participants’ lives.

APPENDIX A: CHECKLIST

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Talking Points
Docket No. 24-1001-1401

Idaho Board of Optometry

- These rules are brought by the Idaho Board of Optometry. The Board is a self-governing, self-supporting board that regulates the practice of optometry in Idaho.
- The Board is served by the Idaho Bureau of Occupational Licenses.
- These rules change the reporting date for a licensee's continuing education.
- Effective January 1, 2017, the time frame for obtaining continuing education will change from a licensee's birth date to a calendar year.
- The Board believes this change will lessen the confusion regarding when continuing education must be earned for license renewal.
- The Board sent a postcard to all licensees regarding this proposed change.
- The proposed change was discussed at open and noticed meetings of the Board.
- There have been three comments received in opposition to the rules, and three comments received in support of the rules.

Talking Points
Docket No. 24-1501-1401

Idaho Board of Professional Counselors
and Marriage and Family Therapists

- These rules are brought by the Board of Professional Counselors and Marriage and Family Therapists. The Board is self-governing and self-supporting, and it regulates the professions of counselors and marriage and family therapists in Idaho.
- The Board is served by the Idaho Bureau of Occupational Licenses.
- This rule adopts the 2014 version of the American Counseling Association Code of Ethics. The current code that is in effect dates back to 2005.
- The new code modernizes counselor ethics.
- The new code was discussed and adopted in open, noticed meetings of the Board.
- Not aware of any opposition.

AGENDA AMENDED #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, January 28, 2015

SUBJECT	DESCRIPTION	PRESENTER
Acknowledgement	Welcome and Acknowledgement that we have family medicine residents from the Family Medicine Residency of Idaho in our audience today.	Chairman Heider
	<u>BOARD OF PHARMACY</u>	
Docket No. 27-0101-1402	Rules of the Idaho State Board of Pharmacy	Mark Johnston, Executive Director
Docket No. 27-0101-1403	Rules of the Idaho State Board of Pharmacy	Mark Johnston, Executive Director
Docket No. 27-0101-1404	Rules of the Idaho State Board of Pharmacy	Mark Johnston, Executive Director
Docket No. 27-0101-1405	Rules of the Idaho State Board of Pharmacy	Mark Johnston, Executive Director
	<u>DEPARTMENT OF HEALTH AND WELFARE</u>	
Docket No. 16-0102-1401	Emergency Medical Services (EMS) – Rules Definitions	Bruce Cheeseman
Docket No. 16-0107-1501	Emergency Medical Services (EMS) Personnel Licensing Requirements	Bruce Cheeseman
	<u>BUREAU OF OCCUPATIONAL LICENSES</u>	
Docket No. 24-1901-1401	Rules of the Board of Examiners of Residential Care Facility Administrators	Tana Cory, Bureau Chief
Docket No. 24-1401-1401	Rules of the Board of Social Work Examiners	Tana Cory, Bureau Chief
Docket No. 24-0901-1401	Rules of the Board of Examiners of Nursing Home Administrators	Tana Cory, Bureau Chief
Docket No. 24-0601-1401	Rules of the Licensure of Occupational Therapists and Occupational Therapy Assistants	Tana Cory, Bureau Chief

Docket No.
[24-1101-1401](#)

Rules of the State Board of Podiatry

Tana Cory,
Bureau Chief

Docket No.
[24-1701-1401](#)

Rules of the State Board of Acupuncture

Tana Cory,
Bureau Chief

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider

Vice Chairman Martin

Sen Johnson(Lodge)

Sen Nuxoll

Sen Hagedorn

Sen Tippetts

Sen Lee

Sen Schmidt

Sen Lacey

COMMITTEE SECRETARY

Erin Denker

Room: WW35

Phone: 332-1319

email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, January 28, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson(Lodge), Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Lacey

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Health and Welfare Committee (Committee) to order at 3:00 p.m. He welcomed family medicine residents from the Family Medicine Residency of Idaho who were in the audience.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin for rules review.

Vice Chairman Martin welcomed Mark Johnston to the podium for rules review.

DOCKET NO. 27-0101-1402 **Mr. Mark Johnston**, Executive Director, Board of Pharmacy (Board), introduced himself, along with pharmacy student Diane Butterfield, who was in the audience. He then addressed **Docket No. 27-0101-1402**, relating to the 2013 federal Compounding Quality Act.

Mr. Johnston said the Compounding Quality Act created a new drug outlet type, the outsourcing facility. These facilities compound drug product and distribute the product to practitioners for in-office administration. Because Idaho had no such registration category, a temporary rule was promulgated.

Mr. Johnston said currently about 100 outsourcing facilities are federally registered at \$15,000 per registration. None are located in Idaho, but they distribute into Idaho. Fees were established at the statutory maximum of \$500 for initial registration and \$250 for renewals. Registration application requirements include (1) being federally registered, (2) the identity of an Idaho registered or licensed pharmacist in charge, and (3) a qualified inspection report. He said the Board received no public comment and there was no expressed opposition. **Mr. Johnston** asked the Committee to approve **Docket No. 27-0101-1402** and stood for questions.

Senator Tippetts asked if costs are greater for nonresident students. **Mr. Johnston** said the fees are statutorily mandated maximum fees and would not necessarily be greater for nonresident students.

MOTION: **Senator Schmidt** moved to approve **Docket No. 27-0101-1402**. **Senator Tippetts** seconded the motion. The motion passed by **voice vote**.

DOCKET NO. 27-0101-1403 **Mr. Johnston** addressed **Docket No. 27-0101-1403**, which regulates non-sterile compounding for the first time. The rule also pertains to sterile compounding, which is further regulated by Rule 240, Idaho Code. Rule 239 addresses compounding, which includes the combining, mixing, and altering of ingredients to create a medication tailored to meet the needs of an individual patient. He outlined details set forth in the rule changes, including labeling, compounding, and record-keeping requirements.

Mr. Johnston said the rule has been negotiated over two years. All public comments were considered, and the Department is not aware of any opposition. He asked for the Committee's approval of **Docket No. 27-0101-1403** and stood for questions.

MOTION: **Chairman Heider** moved to approve **Docket No. 27-0101-1403**. **Senator Nuxoll** seconded the motion. The motion passed by **voice vote**.

DOCKET NO. 27-0101-1404 **Mr. Johnston** addressed **Docket No. 27-0101-1404**. He said this docket provides various forms of clarification and harmony with the 2014 statutory changes and addresses the situation whereby a patient cannot use their dispensed drugs when being admitted to an institutional facility. The rules were publicly negotiated.

The docket clarifies that a foreign graduate is required to obtain 1,500 student pharmacist hours; clarifies that a technician-in-training may only renew two times; harmonizes the standard drug labeling rule with 2014 statutory changes; creates a new limited pharmacy repackaging rule; clarifies when a controlled substance inventory is to be taken; allows pharmacist immunizers to utilize all forms of injectible epinephrine; clarifies that the statutory requirements of nonresident registered pharmacists also pertain to nonresident licensed pharmacists; clarifies pharmacy security requirements; combines various pharmacy security requirements; combines various pharmacy authorized entry rules into one rule; and updates remote dispensing site security and training requirements.

Mr. Johnston reviewed each rule in this docket and brought the Committee's attention to the Board's work with Idaho State University (ISU) College of Pharmacy on a new project to bring retail telepharmacy services to Idaho. He asked the Committee to approve **Docket No. 27-0101-1404** and stood for questions.

Vice Chairman Martin commended the Board and ISU for their cooperative work. **Senator Tippetts** questioned language relating to: agency accreditation, drug dispensing, and technician staffing. **Mr. Johnston** clarified reasons for the language in each instance. **Senator Nuxoll** asked about credits required for graduation (required credits are 1,500) and consent for audio surveillance. **Mr. Johnston** said the subject of audio surveillance was never discussed, but he will bring it to the attention of the Attorney General.

MOTION: **Chairman Heider** moved to approve **Docket No. 27-0101-1404**. **Senator Hagedorn** seconded the motion. The motion passed by **voice vote**.

DOCKET NO. 27-0101-1405 **Mr. Johnston** addressed **Docket No. 27-0101-1405**. As of January 2, 2015, the federal Drug Quality and Security Act preempts states from tracking prescription drug product through the distribution system, which creates the need to strike Idaho Code Rule 809 to eliminate confusion. He said legislation will be coming to the Senate from the House with several statutory changes that were initiated because of this federal act.

Mr. Johnston reviewed each change in detail. He said the Board consulted with the Healthcare Distribution Management Association (HDMA) in developing this rule. He is not aware of opposition. **Mr. Johnston** asked the Committee to approve **Docket No. 27-0101-1405** and stood for questions.

Senator Schmidt asked about exceptions for veterinary distribution. **Mr. Johnston** said there is no clear exception for veterinary distribution, but the topic will be considered next year.

MOTION: **Senator Tippetts** moved to approve **Docket No. 27-0101-1405**. **Senator Schmidt** seconded the motion. The motion passed by **voice vote**.

**DOCKET NO.
16-0102-1401**

Mr. Bruce Cheeseman, Emergency Medical Services (EMS) Section Manager, Bureau of EMS in Preparedness, Department of Health and Welfare (Department), addressed **Docket No. 16-0102-1401**, EMS Rules Definition. He said the change brings the rules into agreement with Idaho Code. The 2014 Legislature adopted S 1328, which amended Idaho Code § 57-1012, as to the definition of Emergency Medical Services or EMS. The rule aligns this chapter of rule definitions for all EMS chapters of rules with statute that became effective on July 1, 2014.

Mr. Cheeseman asked the Committee to approve this docket and stood for questions. **Senator Nuxoll** asked if the language precludes anyone from offering help at a roadside if they are not EMS personnel. **Mr. Cheeseman** said that it does not.

MOTION:

Senator Schmidt moved to approve **Docket No. 16-0102-1401**. **Senator Nuxoll** seconded the motion. The motion passed by **voice vote**.

**DOCKET NO.
16-0107-1501**

Mr. Cheeseman addressed **Docket No. 16-0107-1501**, Emergency Medical Services (EMS) Personnel Licensing Requirements. The rules are being amended to provide flexibility in the continuing education (CE) requirements needed for EMS personnel to renew their licenses. The rules amend the number of CE venues required during each licensure cycle and provide for CE that is taken after an early submission of application to count toward the next licensure period.

Mr. Cheeseman said feedback from EMS personnel across Idaho has been positive. He asked the Committee to approve **Docket No. 16-0107-1501**.

MOTION:

Senator Nuxoll moved to approve **Docket No. 16-0107-1501**. **Chairman Heider** seconded the motion. The motion carried by **voice vote**.

Vice Chairman Martin recognized Tana Cory for the presentation of the next dockets.

Tana Cory, Chief, Bureau of Occupational Licenses (Bureau), described the function of the Bureau, which provides administrative, fiscal, legal, and investigative services to 29 self-governing, self-supporting boards and commissions. She said the Bureau is a dedicated fund agency and does not receive money from either the State General Fund nor any other department or agency.

**DOCKET NO.
24-1901-1401**

Ms. Cory introduced Heidi Bruff Nye from Nampa, Chair of the Board, and addressed **Docket No. 24-1901-1401**, Rules of the Board of Examiners of Residential Care Facility Administrators (Board). She said this anticipated rule change will result in an annual increase of approximately \$24,050 in the Board's Dedicated Fund. The increase is needed because complaints and resulting costs have increased. She said most complaints deal with resident abuse, neglect, or substandard quality of care.

**DOCKET NO.
24-1401-1401**

Ms. Cory next addressed **Docket No. 24-1401-1401**, Rules of the Board of Social Work Examiners. It is anticipated this change will result in an annual increase of approximately \$77,080 in the Board's Dedicated Fund. The Board has also seen an increase in complaints, and investigative costs have doubled from 2010 to 2014.

**DOCKET NO.
24-0901-1401**

Ms. Cory addressed **Docket No. 24-0901-1401**, Rules of the Board of Examiners of Nursing Home Administrators (Board). She introduced a member of the Board, Mr. Keith Holloway from Boise. **Ms. Cory** said it is anticipated this rule change will result in an annual increase of approximately \$8,625 in the Board's Dedicated Fund. The Board has seen its balance declining due to an increase in complaints, investigations, and prosecutions. Most have been relative to resident abuse, neglect, or substandard quality of care.

**DOCKET NO.
24-0601-1401**

Ms. Cory addressed **Docket No. 24-0601-1401**, Rules of the Licensure of Occupational Therapists and Occupational Therapy Assistants. She introduced Kristin Guidry from Meridian, who is a member of the Board. **Ms. Cory** said the Board is decreasing its fees, which will reduce the fees collected annually by approximately \$11,700. She explained that the fees are being lowered to offset the Board's monetary balance, which has increased due to fewer complaints over the last several years. There has also been a decrease in the number of licensees.

**DOCKET NO.
24-1101-1401**

Ms. Cory addressed **Docket No. 24-1101-1401**, Rules of the State Board of Podiatry (Board). She said this rule change is in response to H 356, which passed the House in the 2014 Legislative Session. H 365 allowed the Board to create an inactive status for licensure. Rule 300.05, Idaho Code, establishes the fee for an inactive license, and Rule 425 establishes the inactive status.

**DOCKET NO.
24-1701-1401**

Ms. Cory addressed **Docket No. 24-1701-1401**, Rules of the State Board of Acupuncture. This Board is also reducing its fees. The decrease is anticipated to reduce the amount collected by the Board by \$7,850 annually. She said the Board has not had any complaints in the past three and a half fiscal years. The reduction is intended to lower its overall monetary balance.

Ms. Cory reminded Committee members that she had provided them with a list of the balances for the boards and some history of fee increases and decreases over the last several years. She said these rule changes will ensure the self-sufficiency of each board. She asked the Committee for approval of the six dockets and stood for questions.

Senator Hagedorn asked about the root cause of the increase in investigations.

Ms. Cory called on Heidi Bruff Nye. **Ms. Bruff Nye** explained that hospitals are discharging patients earlier, some of whom are still needing care. They are then admitted into nursing homes, which results in an increase in staff and in complexity of care. There is greater opportunity for errors and complaints.

Senator Hagedorn asked if better training for staff would help, and what the long-term solution would be if complaints continue to rise. **Ms. Cory** said that good education is key, and the Bureau is fiscally responsible and will work hard to minimize complaints.

MOTION:

Senator Hagedorn moved to approve **Dockets Nos. 24-1901-1401; 24-1401-1401; 24-0901-1401; 24-0601-1401; 24-1101-1401; and 24-1701-1401.** **Senator Nuxoll** seconded the motion. The motion passed by **voice vote**.

**PASSED THE
GAVEL:**

Vice Chairman Martin passed the gavel back to Chairman Heider.

ADJOURNED:

There being no further business, Chairman Heider adjourned the meeting at 4:22 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, January 29, 2015

SUBJECT	DESCRIPTION	PRESENTER
Acknowledgement	Welcome and Acknowledgement that we have family medicine residents from the Family Medicine Residency of Idaho in our audience today.	Chairman Heider
<u>DEPARTMENT OF ENVIRONMENTAL QUALITY</u>		
PRESENTATION:	Introductory Presentation for Department of Environmental Quality (DEQ)	Curt Fransen DEQ Director
Docket No. <u>58-0101-1401</u>	Rules for the Control of Air Pollution in Idaho	Tiffany Floyd Air Quality Division Administrator
PRESENTATION:	Idaho Heartland Coalition	Roger Batt Idaho Heartland Coalition
Docket No. <u>58-0101-1402</u>	Rules for the Control of Air Pollution in Idaho	Tiffany Floyd Air Quality Division Administrator
Docket No. <u>58-0101-1403</u>	Rules for the Control of Air Pollution in Idaho	Tiffany Floyd Air Quality Division Administrator
Docket No. <u>58-0105-1401</u>	Rules and Standards for Hazardous Waste	Orville Green Waste Management and Remediation Division Administrator

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, January 29, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson (Lodge), Nuxoll, Hagedorn, Tippets, Lee, Schmidt and Lacey

**ABSENT/
EXCUSED:** None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:06 p.m. He welcomed family medicine residents in the audience and called on Curt Fransen for his presentation.

PRESENTATION: **Curt Fransen**, Director, Department of Environmental Quality (DEQ), introduced himself and the other presenters, all from the DEQ: Tiffany Floyd, Administrator, Air Quality Division; Orville Green, Administrator, Waste Management and Remediation Division; and Paula Wilson, Rules Coordinator.

Mr. Fransen presented an overview of DEQ's rulemaking in general and provided a sense of some of the parameters DEQ worked with in the promulgation process. He explained the relationship between the federal Environmental Protection Agency (EPA) and the State of Idaho relative to environmental programs and implementation of laws and rules by either the EPA or the states.

Mr. Fransen discussed "stringency fee" and explained why DEQ often incorporates federal regulations into state rules by reference. He reviewed the federal environmental laws, federal rules and regulations, authorization, delegation, primacy, and the benefits to state primacy laws. He said DEQ implements state programs in lieu of waiting for the EPA to implement their programs, which allows the State to have control of its own programs. He said DEQ has some flexibility to tailor programs that benefit Idaho, provided the programs are as stringent as federal regulations but no more stringent than necessary.

Mr. Fransen briefly outlined the proposed rule changes being presented at the meeting and discussed what to expect from DEQ in 2016.

Vice Chairman Martin asked Mr. Fransen where DEQ is relative to primacy of surface water. **Mr. Fransen** explained the process so far and said DEQ expects to have rules before the Legislature in 2016.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin for rules review.

Vice Chairman Martin recognized Tiffany Floyd for a presentation on the first three dockets.

DOCKET NO. 58-0101-1401 **Tiffany Floyd**, Air Quality Division Administrator, DEQ, addressed **Docket No. 58-0101-1401**, Rules for the Control of Air Pollution in Idaho. She explained the rule was initiated by the agricultural community and a State legislator. The purpose of the rule change is to clarify the application of Idaho fugitive dust as it pertains to agricultural activities. **Ms. Floyd** said DEQ conducted a negotiating process, held a comment period and had a public hearing. The proposed rule reflects the comments received. The Board of Environmental Quality adopted the rule in mid-November. She asked the Committee to approve **Docket No. 58-0101-1401** and stood for questions.

Senator Nuxoll asked if the rules adhere to federal regulations. **Ms. Floyd** replied this piece is not currently federally approved; it is a clarification to assist implementation of actual rules. **Senator Schmidt** asked if these rules apply to timber industries. **Ms. Floyd** said they did not. **Chairman Heider** asked for a definition of fugitive dust. **Ms. Floyd** defined it as dust created in the activity of farming. **Senator Tippetts** asked if the rules provide relief for individuals engaged in agricultural activities. **Ms. Floyd** answered affirmatively.

TESTIMONY: **Vice Chairman Martin** recognized Roger Batt, who took the podium as representative of the Idaho Heartland Coalition. **Mr. Batt** testified in support of the rules being presented, which he said came about as the result of the federal Clean Air Act. He said this set of rules is a reasonable solution to the current problem.

MOTION: **Senator Tippetts** moved to approve **Docket No. 58-0101-1401**. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

DOCKET NO. 58-0101-1402 **Ms. Floyd** discussed rule changes in **Docket No. 58-0101-1402**, which she said adds clarification to the rule for the control of air pollution in Idaho. The rule ensures consistency with federal regulations and minimizes the burden on regulated facilities.

MOTION: **Senator Lacey** moved to approve **Docket No. 58-0101-1402**. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**. **Senator Nuxoll** asked to be recorded as voting Nay.

DOCKET NO. 58-0101-1403: **Ms. Floyd** addressed **Docket No. 58-0101-1403**, which she said is necessary to ensure that Idaho rules are consistent with federal regulations. She said the rule change is necessary to maintain program primacy and noted the types of incorporation by reference. DEQ did not conduct negotiation on rulemaking, due to the nature of the rule. Public hearings were held, and no comments were received.

Senator Nuxoll asked questions about exceptions from the federal code. **Mr. Fransen** answered that the federal regulations do provide some flexibility.

MOTION: **Chairman Heider** moved to approve **Docket No. 58-0101-1403**. **Senator Schmidt** seconded the motion. The motion passed by **voice vote**. **Senator Nuxoll** asked to be recorded as voting Nay.

Vice Chairman Martin recognized Orville Green for presentation of the next docket.

DOCKET NO. 58-0105-1401 **Orville Green**, DEQ, addressed **Docket No. 58-0105-1401**, which he said is an adoption by reference because it is required by law. He said the rules are adopted on an annual basis and incorporate the changes in the federal Hazardous Waste Rules from July 1, 2013, through June 30, 2014.

Mr. Green said the rules enable Idaho to maintain primacy over the Hazardous Waste Program in lieu of the EPA. He asked the Committee to approve **Docket No. 58-0105-1401** and stood for questions.

MOTION: **Senator Schmidt** moved to approve **Docket No. 58-0105-1401**. **Senator Tippetts** seconded the motion. The motion carried by **voice vote**.

**PASSED THE
GAVEL:**

Vice Chairman Martin passed the gavel back to Chairman Heider.

ADJOURNED:

There being no further business, Chairman Heider adjourned the meeting at 4:49 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant

JOINT
**SENATE HEALTH & WELFARE COMMITTEE
AND
HOUSE HEALTH & WELFARE COMMITTEE**
8:00 A.M.
Lincoln Auditorium
Friday, January 30, 2015

PUBLIC HEARING

SUBJECT DESCRIPTION	PRESENTER
THE SENATE AND HOUSE HEALTH & WELFARE COMMITTEES WILL HOLD A PUBLIC HEARING ON H&W ISSUES. MEETING TIME IS 8:00 - 10:00 a.m.	Chairman Heider
THE PUBLIC WILL HAVE THE OPPORTUNITY TO EXPRESS CONCERNS RELATED TO HEALTH & WELFARE PROGRAMS.	
TESTIMONY WILL BE LIMITED TO 3 MINUTES PER PERSON	

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

SENATE COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
JOINT MEETING
SENATE HEALTH & WELFARE COMMITTEE
HOUSE HEALTH & WELFARE COMMITTEE

DATE: Friday, January 30, 2015

TIME: 8:00 A.M.

PLACE: Lincoln Auditorium

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Hagedorn, Tippetts, Lee and Schmidt

Chairman Wood, Vice Chairman Packer, Representatives Hixon, Perry, Romrell, Vander Woude, Beyeler, Redman, Troy, Rusche and Chew

ABSENT/ EXCUSED: Senators Lodge, Nuxoll and Lacey

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 8:01 a.m.

TESTIMONY: **Jessica Chilcott**, District 7, Idaho, said Optum's catalyst for change had brought an increase to denials of service, unpaid workload by case workers and unresponsiveness to filed grievances.

Terry Sterling, Idaho Community Action Network, on behalf of Jenna Silvia, gave her support for and desire to see Medicaid expanded in Idaho as it would increase job opportunities in the healthcare industry.

Brenda Smith spoke about her experience with the adoption of special needs children. She felt parents were not given enough of a voice to guide the care of these children's lives within the school and mental healthcare systems.

Cameron McCown requested that a non-biased oversight authority of Optum be established in order to review the procedures and care given to patients and ensure that care was adequate, proper and effective.

Eric Makrush, Foundation for Government Accountability, stated to prevent federal government dependency, problems within the Medicaid system should be addressed by a state level healthcare system to maintain control over its development and implementation.

Aaron White, President, Idaho American Federation and Congress of Industrial Organizations (IAFL-CIO), expressed support of Medicaid expansion. Medicaid expansion allows for economic growth as well as stability of healthcare in rural communities and across Idaho.

Anita Santos, Executive Director, Idaho Academy of Family Physicians (IAFP), expressed the IAFP's support for Medicaid expansion. She said the overall effect of providing affordable healthcare to more people was a less costly healthcare system. The IAFP was committed to finding solutions to Idaho's healthcare issues.

Rebeka Casey said the critically needed Community Based Rehabilitation Services (CBRS) component of care given to special needs children has been reduced by Optum. She asked for an investigation into Optum's violation of due process in their denial request appeals process and into Optum's utilization of evidence-based practices.

Jeff Marino, Stellar Mental Health and Mediation, testified on his professional experience with Optum; their cutback of CBRS services, the lack of accountability and the decline in care for the youth in need.

David Decker, President, Self Advocate Leadership Network, said Medicaid expansion would correct the coverage gap for those who do not qualify for traditional Medicaid nor federal tax credits yet are unable to afford health insurance.

David Murgiotio, Family Medicine Residency of Idaho, said affordable healthcare was a significant issue for people who fall between the income gap of too much for Medicaid and not enough for tax credits. He expressed his appreciation for the legislative support of the Healthy Idaho Plan.

Ashley Piaskowski, Patient Enrollment Specialist, Heritage Health, expressed her support of Medicaid expansion to close the coverage gap in Idaho.

Vanessa Bates Johnson, Access Community Base Services, stated a dissolution of Optum was unnecessary, but rather oversight and regulation should be implemented to include adequate public disclosure and metrics for the progress of mental health services provided by Optum.

Randy Shelton expressed concern over the dwindling number of hours Transportation Support Services allotted for individuals in need and the effect that caused to their feelings of independence; his son was a good example as he recently had to quit his volunteer activity for fear of lack of transportation.

Amanda Harris, patient, Stellar Mental Health, stated she was denied services through Optum despite her doctor's letters in support of her need. Although her services recently had been restored, there was a need to review Optum's determination of access to mental health services.

Diane Overall expressed frustration with the difficulty to appeal denial requests from Optum. She said the break in care resulted in severe regression of her grandson's condition even after eventual reinstatement of care.

Ali Landers said a transition program for those recovering or managing mental health issues was needed to allow them to contribute to society.

Douglas Alles, Director, Catholic Charities of Idaho, stated the financial burden of no or inadequate healthcare presented significant challenges to families and individuals seeking to remove themselves from government and charitable assistance. He said he supported the Healthy Idaho Plan.

Ilene Kingery spoke about the benefits her son had received from mental health services through CBRS. She said there was need to review Optum's denial rate against the service denials and subsequent emergency care provided to Idaho.

Beverly Hines, licensed professional counselor, said whole family care was an essential component to the ongoing health of children and as such should not be left out of mental health services provided to families.

Liza Long said she supported the expansion of Medicaid to close the coverage gap. She said Optum's denial of services may be shifting the cost of preventative mental healthcare to the juvenile justice system. She stated there was a need to review Optum's denial of services and those children who then received emergency treatment or went into the juvenile justice system.

Karri Schock said her family experienced the her son's behavioral regression due to Optum's policy for an ongoing 90 day reevaluation process, which included a break in care while under review. Optum must address the continuity of care issues faced by mental health patients during this 90 day reevaluation as well as the high level of service denials.

Joshua Grade said budget cuts and denial of Medicaid put the legacy of Idaho taking care of its own in jeopardy, but adjustments to the system could change that course for the better.

TJ Barr, case worker, CBRS, said the changes Optum had made to the standard of care for children were a detriment to the child. He asked for a review of Optum's systems and processes to be done before the upcoming contract renewal between Idaho and Optum.

Chairman Heider asked Dallas Dulany, 2nd grader from Gateway School, to share about his favorite football team and his school. **Chairman Heider** said the little boy was one example of the children who had been talked about during the committee meeting.

Kevin O'Sullivan told the story of his experience with lack of insurance; he supported the Healthy Idaho Plan.

Brandi Hooker, President, Idaho Dental Hygienist Association, urged the Legislature to support the federal grant for workplace innovation in the oral healthcare field. She said these grants would provide improved care to Idaho citizens.

Mary Syms-Pollot said there was a great need for revision to the cumbersome, inefficient healthcare system processes.

Carol Augustus expressed her support for Medicaid expansion.

Matthew Johnson, Glens Ferry Healthcare Incorporated, expressed his support for the Healthy Idaho Plan.

Veronica Dulany said peer related counselors were an important component of behavioral based counseling, however, this critical service had been severely reduced by Optum.

Greg Dickerson, Mental Health Providers of Idaho, said a strategic plan for the renewal of Optum's contract should outline metrics and real time outcome data to meet the needs of the patients.

Marie Milanez expressed her appreciation for the Starr program; her child had benefited from their mental health services.

Jessica Trent, Program Director, Starr Family Behavioral Health, said there was a need for an assessment of the administrative overload mandated by Optum for both adequate reimbursement and redundancies of procedures already in practice.

Zach Warren, Pearl Health Clinic, said Optum's takeover of mental health services had resulted in a decline in patient care as well as a reduction in payment for services.

Sathya Shankar said up until Optum's management of the mental health services her son was making excellent progress. She said a service denial from Optum caused regression in her son's mental health. **Ms. Shankar** expressed the need for the current system to reflect the continuing needs of her child and children like him.

Chairman Wood gave a recap of the testimonies presented to the Committee. He said the two primary topics were the healthcare coverage gap and the development of managed care into accountable care within the universal healthcare system. He said there would be challenges in the ongoing shift away from the traditional medical system to an integrated system. **Chairman Wood** said public input was a valuable resource and thanked those who testified today.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 9:59 a.m.

Senator Heider
Chair

Erin Denker
Secretary

Jenny Smith
Assistant Secretary

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, February 02, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
PRESENTATION:	Fun, Facts, and Myths	Richard Armstrong Director, Department of Health and Welfare
<u>RS23202</u>	Relating to Dentistry - Amending to Require Licensees to Provide Notice of Felony Convictions	Susan Miller Dentistry Board
<u>RS23211</u>	Relating to Dentistry - Amending to Remove Language & Clarify License Status	Susan Miller Dentistry Board
<u>RS23220</u>	Amending to Prohibit Public Assistance Recipients from accepting direct payment of child support or forgiving unpaid support	Kandee Yearsley Department of Health and Welfare

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
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MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 02, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson (Lodge), Nuxoll, Hagedorn, Tippets, Lee, Schmidt and Lacey

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m. and welcomed Richard Armstrong.

PRESENTATION: **Richard Armstrong**, Director, Department of Health and Welfare (Department), presented on Fun, Facts, and Myths (see attachment 1). He said that welfare is steeped in mythology rather than facts.

Mr. Armstrong said most welfare recipients are not drug users. Idaho does screen for drugs and sends users to drug treatment, which helps both the welfare recipient and the children.

Regarding child support, the Department has created many effective tools to recoup child support money from the non-custodial parent to the custodial parent. Most of the problems occur because people just don't have the money.

Mr. Armstrong said that getting too many vaccines at one time will not overwhelm a child's immune system. Studies by the Centers for Disease Control have shown, in theory, healthy infants could safely get up to 100,000 vaccines at once, provided the inoculations are administered correctly. For airborne diseases such as measles, if 90 percent to 95 percent of individuals are immunized, the general public is in safe territory.

Mr. Armstrong emphasized that drug use is voluntary but drug addiction is not. He said addictive drugs can forever alter the brain. Prescription pain medications, which are everywhere, present the greatest problem; more overdoses occur with prescription pain medication than heroin and cocaine combined.

Mr. Armstrong continued his examination of welfare fiction which included the myths of foster parenting requirements, welfare queens, Medicaid eligibility, the food stamp program (SNAP), and Ebola fears.

Chairman Heider called on Susan Miller for her presentation on **RS 23202**.

RS 23202

Susan Miller, Executive Director, Board of Dentistry (Board), presented **RS 23202**, which amends Idaho Code § 54-923 and provides for revocation of a license for conviction of a crime. The proposed amendment would add a requirement that licensees must report to the Board any felony conviction within 30 days of conviction. Currently there is no requirement for a licensee to report such information other than in an initial application or biennial renewal application. For that reason, it is not unusual for the Board to learn of a conviction months after the event.

Ms. Miller said the Board feels it is in the interest of public safety to add this requirement, which is why the amendment is being brought back for further consideration with revised wording that would be more acceptable to the Committee.

MOTION: **Senator Hagedorn** moved to send **RS 23202** to print. **Vice Chairman Martin** seconded the motion. The motion passed by **voice vote**.

RS 23211 **Ms. Miller** addressed **RS 23211**. A portion of Idaho Code § 54-920 concerns renewal of licenses, and § 54-921 relates to reinstatement of a license. This amendment clarifies that failure to renew a license will result in the expiration of a license and that an expired license will be cancelled if not renewed within the 30-day grace period as set forth in statute.

Ms. Miller explained the legislation also establishes requirements to reinstate a cancelled license if it is cancelled for less than two years and requires reinstatement if cancelled for longer than two years.

Senator Hagedorn asked about a strikeout referring to renewal notifications. **Ms. Miller** explained that each licensee receives renewal notices prior to the renewal date, in addition to a final notice, sent by certified mail.

MOTION: **Senator Schmidt** moved to send **RS 23211** to print. **Vice Chairman Martin** seconded the motion.

SUBSTITUTE MOTION: **Senator Hagedorn** made a substitute motion to hold **RS 23211** until the end of the week when the bill's sponsor can provide information in the statute related to notification requirements.

Ms. Miller referred the Committee to the pages of the rule that fully define notification requirements.

ROLL CALL VOTE: **Chairman Heider** called for a roll call vote on the substitute motion to hold **RS 23211** until the end of the week to receive additional information on notification requirements. **Senators Johnson, Nuxoll, Hagedorn** and **Vice Chairman Martin** voted aye. **Senators Tippetts, Lee, Schmidt, Lacey** and **Chairman Heider** voted nay. The motion **failed**.

ROLL CALL VOTE: **Chairman Heider** called for a roll call vote on the original motion to send **RS 23211** to print. **Senators Johnson, Hagedorn, Tippetts, Lee, Schmidt, Lacey** and **Chairman Heider** voted aye. **Senator Nuxoll** voted nay. The motion **carried**.

RS 23220 **Kandee Yearsley**, Child Support Bureau Chief, Department of Health and Welfare (Department), Division of Welfare, presented **RS 23220**, which pertains to the collection of child support and the reimbursement of public assistance. Rules relating to child care, Temporary Assistance for Families in Idaho (TAFI), and Medicaid require benefit program recipients who receive benefits for themselves and/or their children to cooperate with Child Support Services.

Ms. Yearsley explained the reason for this requirement is to either obtain reimbursement for funds expended on behalf of the family or to assist public assistance recipients with enforcement of their court order to provide income into the household, which could reduce or eliminate these families' reliance on future public assistance. The rule change would specify that a benefit recipient does not have the authority to forgive or to receive direct payment of child support during the time they are receiving public assistance.

Ms. Yearsley asked the Committee to approve **RS 23220** and stood for questions.

Mr. Scott Keim, Deputy Attorney General, Department of Health and Welfare (Department), took the podium to answer Committee members' questions relating to the legal terminology in the amendment.

MOTION: **Vice Chairman Martin** moved to print **RS 23220**. **Senator Lee** seconded the motion. The motion passed by **voice vote**. **Senator Hagedorn** asked to be recorded as voting nay.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:30 p.m.

Senator Heider
Chair

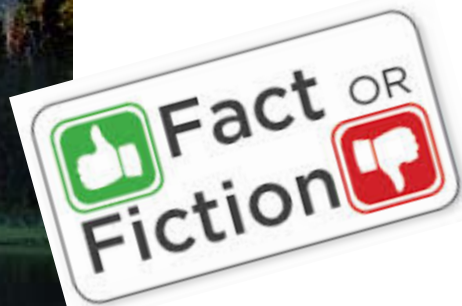
Erin Denker
Secretary

Jeanne' Clayton
Assistant

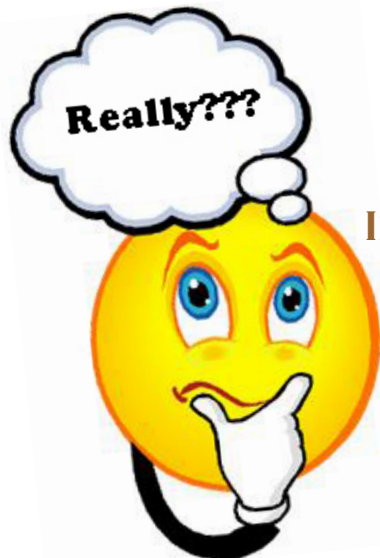
The logo for the Idaho Department of Health and Welfare, featuring the word "IDAHO" in a large, bold, black serif font. The background of the slide includes a scenic view of a mountain range and a lake, with the logo partially overlapping the mountain.

Department of
Health and Welfare

FUN FACTS AND MYTHS



WELFARE QUEENS, DEADBEAT DADS AND BEING A FOSTER PARENT



DICK ARMSTRONG
DIRECTOR

IDAHO DEPARTMENT OF HEALTH AND WELFARE

BUSTED



IDAHO DEPARTMENT OF
HEALTH & WELFARE



MYTH: MOST WELFARE RECIPIENTS ARE DRUG USERS

BUSTED

Fiction: That's apparently what Florida governor Rick Scott thought, too.

The state of Florida began drug testing welfare recipients in 2011. About 2% tested positive for drug use. Federal statistics show that the rate of drug use among welfare recipients is about the same as it is for the general public.



IDAHO DEPARTMENT OF
HEALTH & WELFARE



MYTH: IT'S MY MONEY. I DON'T HAVE TO PAY CHILD SUPPORT IF I DON'T WANT TO.

BUSTED

Fiction: Sorry, but the urban legend of the deadbeat dad is slowly dying.

Our tool chest for collecting money for Idaho children includes mandatory wage withholding by employers, garnishing federal and state tax returns and lottery winnings, and even accessing bank accounts. We can also suspend your driver's license, fishing, hunting and even professional licenses. And we can even take your passport—while you are out of the country!!



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HEALTH & WELFARE

BUT DID YOU KNOW.....?

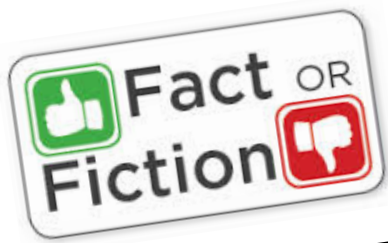


- In 1997, \$18 M. in child support was collected through wage withholding. In SFY 2013, it was \$104 M.
- One-half of all people notified their licenses were going to be suspended ponied up. But, about 160 licenses are still suspended each month.
- 15% of people who pay child support are women.
- Idaho collects 62% of support owed, but over \$600 M. is past due. 30% of custodial parents never receive one cent.



- There is a big difference between deadbeat and deadbroke dads (and moms). We sympathize and work closely with deadbroke payers—they want to support their children, but often are victims of the economic times.





**MYTH: GETTING TOO MANY VACCINES AT ONE TIME
WILL OVERWHELM MY CHILD'S IMMUNE SYSTEM.**

BUSTED

Fiction: There are more bacteria in your child's mouth than there are people in the world.

Compared to what they typically encounter and manage during the day, vaccines are literally a drop in the ocean for children.

Studies by the CDC have shown, in theory, healthy infants could safely get up to 100,000 vaccines at once.

The bottom line: It's safe to give your child simultaneous vaccines or vaccine combinations.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUT DID YOU KNOW.....?



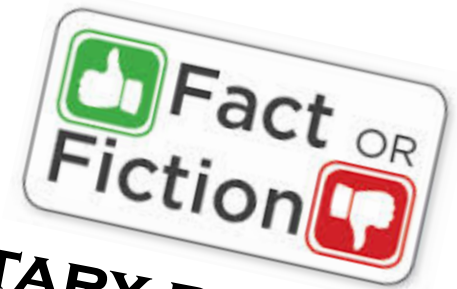
- The state purchases and supplies children's vaccines to healthcare providers so all children have access. Over 600,000 children's vaccines were distributed by the Idaho Immunization Program last year.



- Idaho has the second highest exemption rate in the nation. Idaho law makes it convenient for parents to declare an exemption during school registration.
- Idaho has been steadily increasing its vaccination rate, improving from 48th in the nation in 2007, to 23rd in 2013.



MYTH: DRUG ADDICTION IS A VOLUNTARY BEHAVIOR



BUSTED

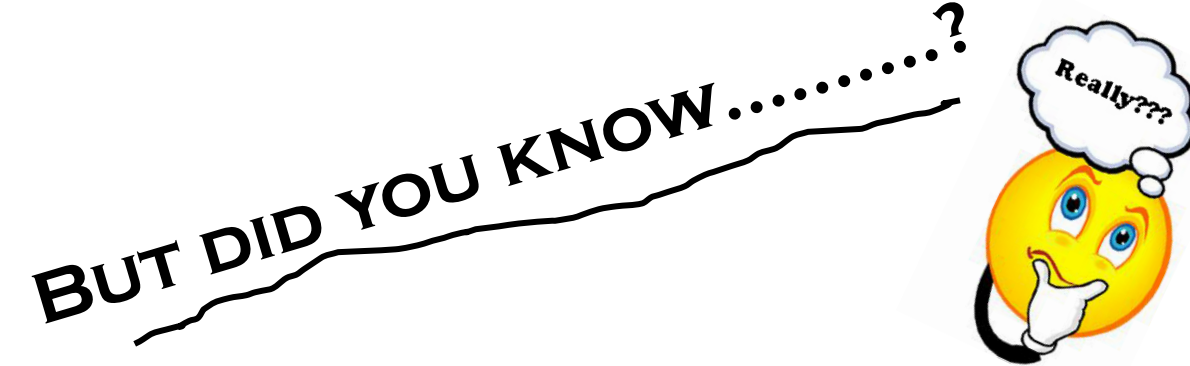


Fiction: If you are going to be a volunteer, don't raise your hand for this one.

Addictive drugs actually change your brain in ways that result in compulsive, and even uncontrollable drug use. Also, many people with mental illness self-medicate, becoming addicted to drugs or alcohol. Substance use disorders can be very complex for effective treatment.



IDAHO DEPARTMENT OF
HEALTH & WELFARE



Myth: Prescription pain medications are safer than street drugs.

Truth: Since 2003, prescription pain medications like Vicodin and OxyContin have been involved in more overdose deaths than heroin and cocaine combined.



Myth: Marijuana is not addictive.

Truth: 1 of 11 people who use it become addicted.
Hey Oregon, what are you thinking?

Myth: Hard liquor drinks are more addictive than beer or wine.

Truth: Alcohol is king as the most addictive substance in the U.S. One of every 12 adults suffer from its abuse or dependence. And it does not matter what liquid form you drink. (But wine stains on the white carpet are harder to get out!)





MYTH: I COULD NEVER BE A FOSTER PARENT BECAUSE I'M NOT MARRIED AND DON'T MAKE A LOT OF MONEY AND DON'T OWN MY HOME AND DON'T EVEN MAKE MY BED IN THE MORNING.

BUSTED



Fact: You're a perfect match—for some lucky child.

You just need compassion, patience, and a willingness to help a child and their family during a difficult time. You don't have to be married and you can rent. The only financial requirement is that you have enough income to support yourself and your family aside from the money you are reimbursed to care for a child living in foster care. You can call 2-1-1 Idaho CareLine for more info.



IDAHO DEPARTMENT OF
HEALTH & WELFARE




WELFARE QUEEN MYTH: “THERE’S A WOMAN IN CHICAGO. SHE HAS 80 NAMES, 30 ADDRESSES, 12 SOCIAL SECURITY CARDS. ... SHE’S GOT MEDICAID, GETTING FOOD STAMPS AND SHE IS COLLECTING WELFARE UNDER EACH OF HER NAMES. HER TAX-FREE CASH INCOME ALONE IS OVER \$150,000” – RONALD REAGAN DURING 1976 PRESIDENTIAL CAMPAIGN



Fiction, But Reagan Won the Presidency!

Actually, it was not all fiction. He put the facts together from three different women, all who were abusing the system.

But that was 1976.



Welfare reform in 1996 dethroned the welfare queen and put her to work. States were given more control of welfare programs, instituting work requirements and time limits for benefits. As a result, people now have to be working or taking part in job search activities if they receive Food Stamps or cash assistance.

Technology is now the ruler. DHW's benefit eligibility process relies on more than 20 state and federal databases to verify identity, obtain or check information, and reduce fraud and abuse





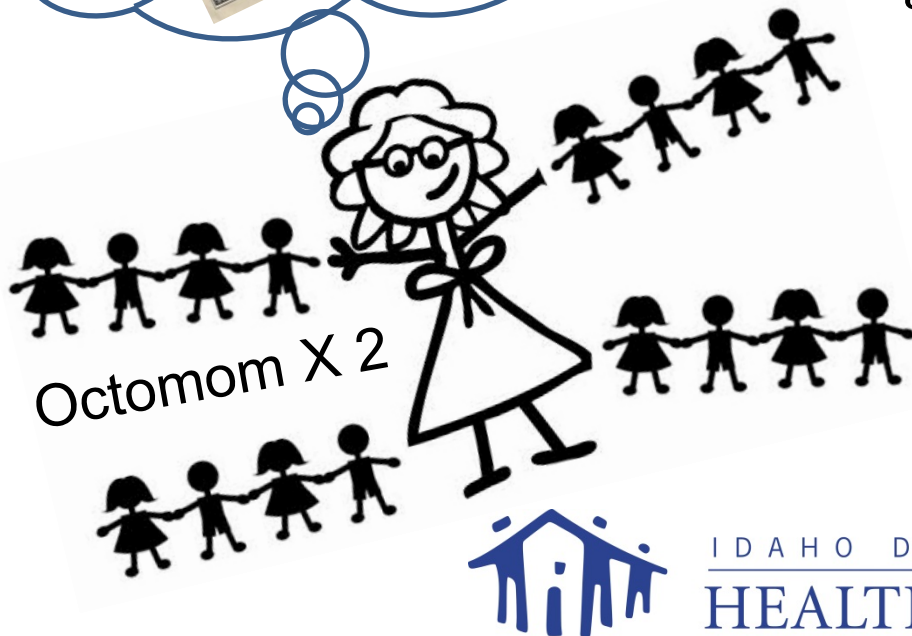
MYTH: A WOMAN CAN CASH IN ON WELFARE BY HAVING MORE CHILDREN

BUSTED



Fiction: In Idaho, the maximum cash assistance available is \$309/month. That's for 1 child... or 16.

- There's a 2-year lifetime limit for cash assistance.
- The program requires recipients to be in job training or working -- No freeloaders!!
- Each month, 200 family households receive cash assistance. That's out of 578,000 Idaho households!



IDAHO DEPARTMENT OF
HEALTH & WELFARE



MYTH: POOR PEOPLE CAN GET HEALTHCARE THROUGH MEDICAID

BUSTED

Fiction: Healthy, working age adults are not eligible for Idaho Medicaid—even if they are poor or unemployed or homeless.

Who's eligible?

- Low-income pregnant women
- Children from low income families
- People with disabilities
- Low-income elderly
- Adults, with children in the home, who are extremely low-income.



Can you believe a monthly income limit of \$517/month for a family of four? \$518 earnings and you buy your own insurance....with what?

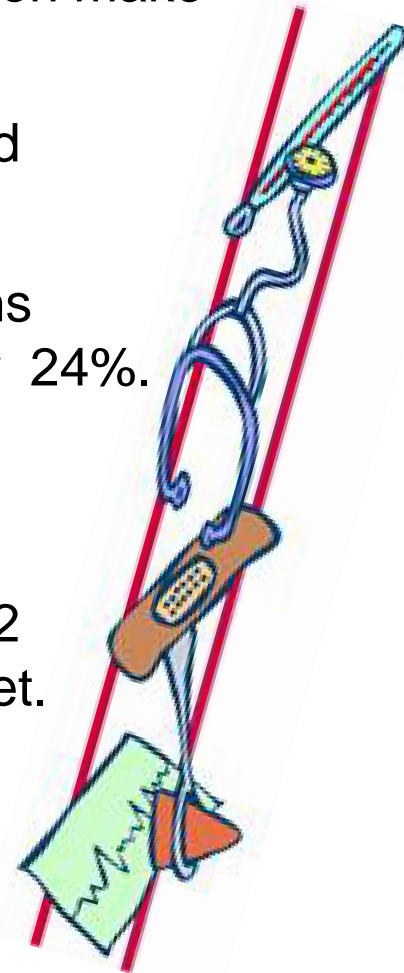
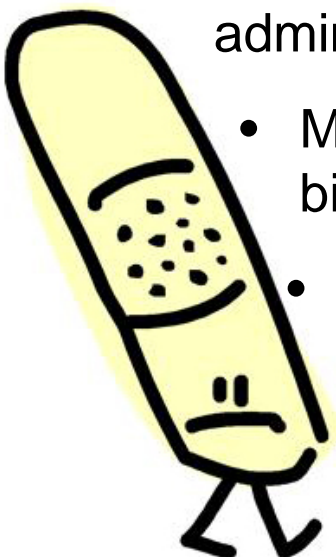


IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUT DID YOU KNOW.....?



- Medicaid averaged 252,600 participants in SFY 2014. Children make up 74% of enrollment, but only 36% of expenses.
- Medicaid pays for approximately 44% of all prenatal care and deliveries in Idaho.
- The federal government pays about 70% of all medical claims in the program. State general fund (tax dollars!) account for 24%.
- 97% of Medicaid's budget is paid out in claims. 3% is for administration and personnel.
- Medicaid's SFY 2015 budget is a little more than \$2 billion and accounts for 80% of DHW's total budget.
- Stump the Chump: Do you know the difference between Medicare and Medicaid?



IDAHO DEPARTMENT OF
HEALTH & WELFARE



ILLEGAL IMMIGRANTS CAN RECEIVE FOOD STAMPS

BUSTED

Fiction: Undocumented immigrants have never been eligible for Food Stamps.



- Legal immigrants can only get Food Stamps if they have lived in the U.S. for at least five years.
- Refugees can receive Food Stamp benefits if they meet other eligibility requirements.
- Many immigrants are reluctant to apply for Food Stamps because of language barriers or fear it will affect their immigration status.



BUT DID YOU KNOW.....?



- 82% of all SNAP benefits go to households with children, elderly or people with a disability.
- The average Food Stamp benefit is \$115/month. That's \$3.83/day or \$1.28/meal. A 4-piece Chicken McNuggets Happy Meal costs \$2.99.



- Food Stamps cannot be used for alcohol, tobacco, pet food, medicine, household supplies, or prepared and hot foods.
- Unless a small child is in the household, participants must work or be in job training.
- Increased oversight has reduced trafficking to less than 1% of benefits.



- Idaho's enrollment peaked at 238,000 in January 2012, but is now less than 200,000





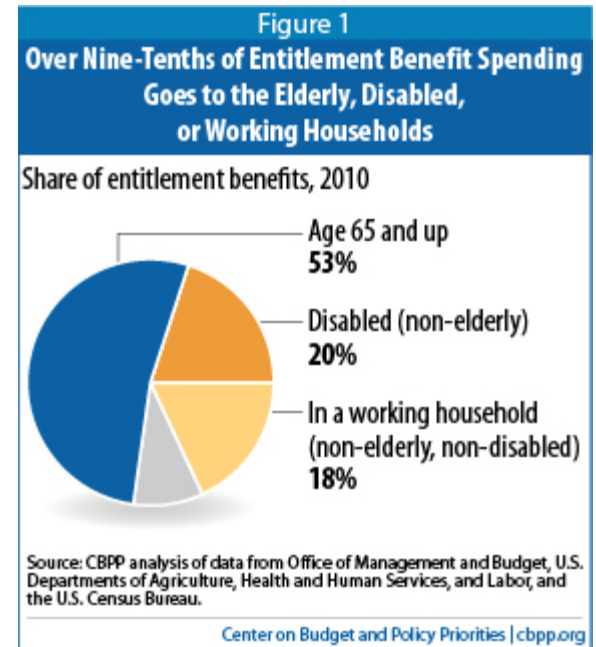
WELFARE SPENDING ON NON- WORKERS IS SINKING THE U.S BUDGET



Fiction: More than 90% of Welfare budget goes to the elderly, disabled or members of working households. *Center on Budget and Policy Priorities, 2012*

Only 12% of federal budget goes to safety net programs. The big federal spenders:

- 24% to Social Security
- 22% to Medicare and Medicaid
- 19% for Defense and Security
- 8% for federal retirees and veterans benefits and pensions.



Quiz: Do you have Ebola?



Have you touched the vomit, blood, sweat, saliva, urine or other gross bodily fluids from someone who has Ebola?



☐ Yes

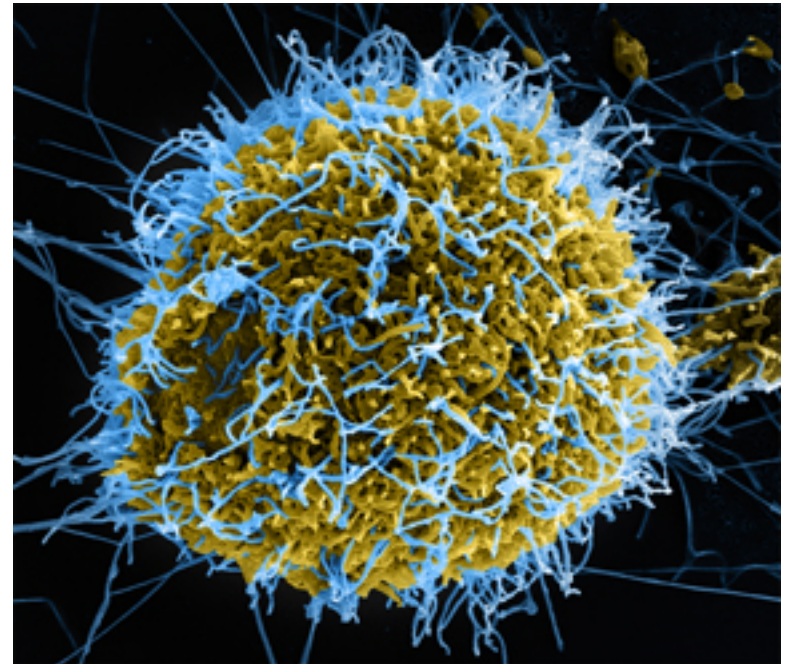
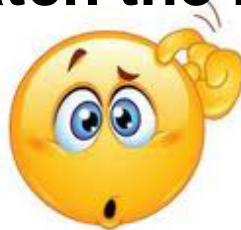
☐ No

If No, you do not have Ebola.

Do you watch the news?

☐ Yes

☐ No



If yes, you have a highly contagious strain of Ebola, called Fearbola.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

IDAHO

Department of
Health and Welfare



Questions?



IDAHO DEPARTMENT OF
HEALTH & WELFARE

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, February 03, 2015

Meeting will adjourn today at 4:15

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Gubernatorial Appointment Hearing	Michael Gibson of Nampa, Idaho, was appointed to the Commission for the Blind & Visually Impaired to serve a term commencing July 1, 2014, and expiring July 1, 2017	Michael Gibson
Presentation:	Idaho Office of Drug Policy, Cannabis Oil (CBD)	Elisha Figueroa Administrator Idaho Office of Drug Policy

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 03, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Senators Johnson (Lodge), Hagedorn, Tippetts, Lee, Schmidt and Lacey

ABSENT/ EXCUSED: Vice Chairman Martin and Senator Nuxoll

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:07p.m.

GUBERNATORIAL APPOINTMENT HEARING: **Chairman Heider** welcomed Michael Gibson of Nampa, Idaho who was appointed to serve on the Idaho Commission for the Blind and Visually Impaired Board (ICBVIB) for a term commencing July 1, 2014 and expiring July 1, 2017.

Mr. Gibson said he has spent six years on the board of the ICBVIB, which were some of his most rewarding years in public service. He said he has enjoyed being able to help blind or visually impaired Idahoans in their quest to lead independent and meaningful lives. He referred to his work at the Boise State University Disability Resource Center where he assisted college-age individuals navigate the campus. He said this experience was especially rewarding.

Mr. Gibson acknowledged and thanked Nancy Wise, Administrator, ICBVIB, who was in the audience. He said he looks forward to continuing to provide leadership and to serve the ICBVIB.

Chairman Heider asked how many blind or visually impaired individuals in Idaho utilize the ICBVIB's resources. **Mr. Gibson** said approximately 450 older individuals receive ongoing services and about 1,100 individuals have received either one-time services or are receiving ongoing services.

Senator Hagedorn asked about current roadblocks to the blind or visually impaired in higher education, especially in math and some of the sciences. **Mr. Gibson** said the issue is challenging but evolving. He said with improved computer technology, these subjects are becoming more accessible. Work is also being done to encourage publishers of higher education textbooks to provide access to the blind via audio resources.

Mr. Gibson described his experience with a rehabilitation center for the blind in Colorado and expressed admiration for the exceptional resources available in Idaho.

Chairman Heider thanked Mr. Gibson for his contributions to the ICBVIB. He welcomed Elisha Figueroa to the podium for her presentation.

PRESENTATION: **Elisha Figueroa**, Administrator, Office of Drug Policy (ODP), gave a presentation on Cannabidiol (CBD) Oil drug studies (see attachment 1). She explained the characteristics of CBD oil and its difference from THC and medical marijuana. She informed the Committee that the Epidiolex trial starting in the spring of 2015 was supported by the ODP. The results would be used to determine the efficacy of CBD oil on seizure disorders.

Ms. Figueroa stated CBD oil is currently classified as a Schedule I drug by the FDA, making it illegal by the federal government. Additionally, if Idaho were to legalize CBD oil, the traditional medical community would not be involved because it is not an FDA approved drug.

Ms. Figueroa concluded by stating the ODP is supportive of the FDA trials underway and will use the results of those trials to make decisions on its recommendation on the legalization of CBD oil.

Senator Hagedorn asked Ms. Figueroa if ODP had communicated with the Department of Commerce about promoting Idaho as one of only two states in the western U. S. that does not legalize any type of marijuana. **Ms. Figueroa** replied that such communication had not taken place.

Chairman Heider thanked Ms. Figueroa for her presentation. He said it provided useful information to the Committee.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:45 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant Secretary

Presentation #1

The Argument for FDA-Approved CBD Drug Studies in Idaho

Governor's Office of Drug Policy

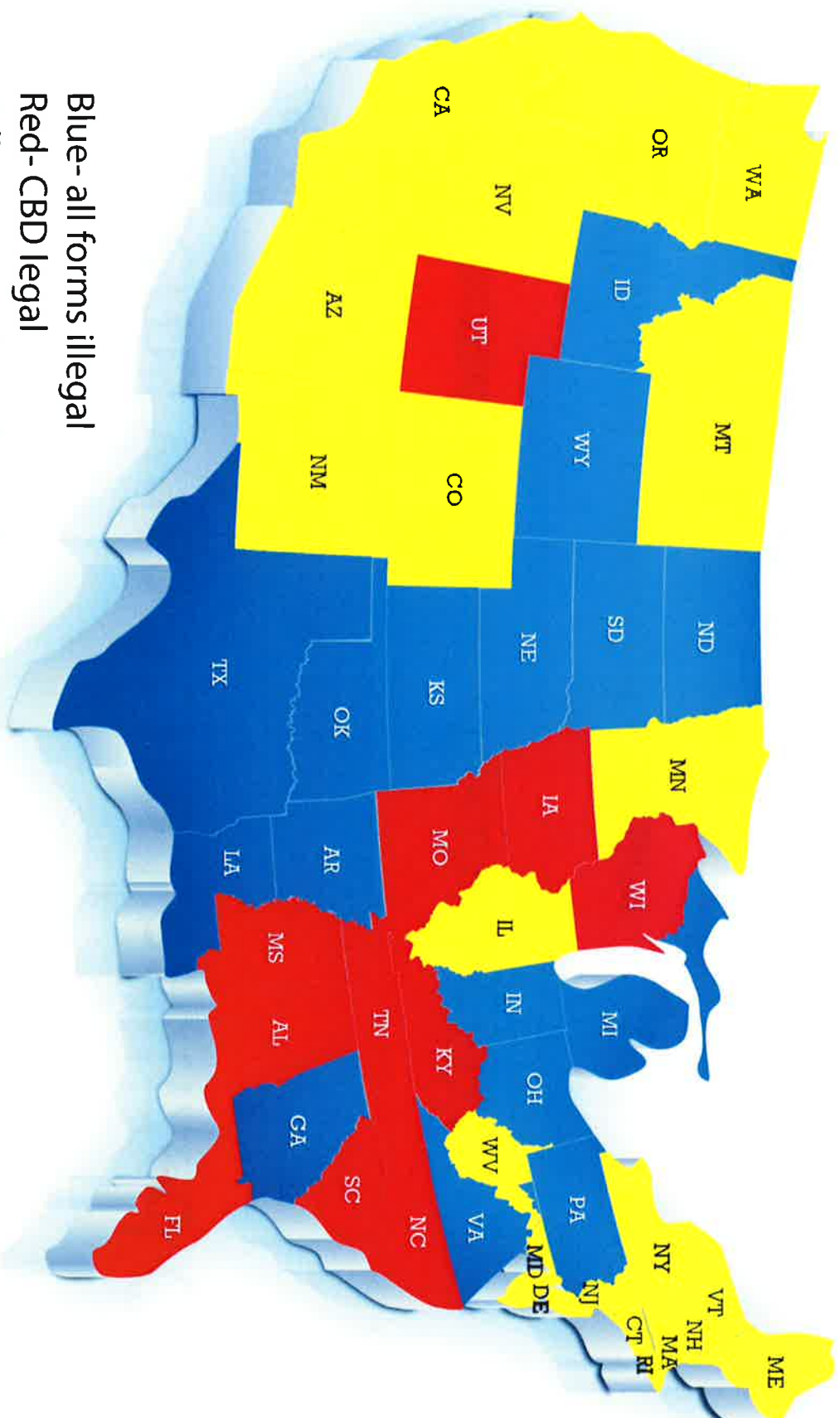


Cannabidiol Oil (CBD)

- One of many components of cannabis plant
- No psychoactive effects
- May show some benefit for intractable seizures
- Administered orally in oil form

Marijuana States

Blue- all forms illegal
Red- CBD legal
Yellow- recreational & 'medicinal'





Concerns with State Legalized CBD

- Schedule I drug
- Not deemed safe and effective by FDA
- Very limited unbiased studies
- Accessed through “budtenders”

- Rely on advice of “budtenders” regarding strain and dosage
- Product purity concerns
- Unregulated extraction process allows for unknown amounts of THC which can cause seizures
- Contaminants such as mold, fungi, E Coli, other toxins (New Haven University)
- May cause negative drug interactions



"Buddender Derek Richards, left, helps Carson Jones of Lincoln, Neb., while Jones' brother Jack, also of Lincoln, finishes his order and security guard Dirk Smith, back, signals to buddenders how many customers are waiting inside the store. KAI-HUEI YAU — Tri-City Herald"

Daniel Friedman, M.D.,
epileptologist and a clinical
neurophysiologist at the NYU
Comprehensive Epilepsy Center
opined, “More studies are needed
to understand the potentially
complex interactions between
CBD and other drugs but in the
meantime, frequent monitoring
of drug levels is warranted in
children taking CBD-containing
products, including medicinal
cannabis” .

American Epilepsy
Society (2014) New
reports of Epidiolex
efficacy and safety
presented at the
American Epilepsy
Society Annual
Meeting. Retrieved
from:

<http://www.newswise.com/articles/view/626892/>

Research Reported December 2014

American Epilepsy Society

- After 3 months, 39% of parents reported CBD reduced seizures by more than 50%
- 3 of 5 patients showed decreased seizure frequency
- 4% Experienced more seizures
- 1 of 5 showed increased frequency by 5%

Devinsky, O., Sullivan, J., Friedman, E. T., March, E., Laux, L., Hedlund, J., ... & Cilio, M. (2014). Efficacy and safety of Epidiolex (cannabidiol) in children and young adults with treatment-resistant epilepsy: Initial data from an expanded access program, 3-303, American Epilepsy Society Annual Meeting.

www.aesnet.org

Geffrey, A., Pollack, S., Paolini, J., Bruno, P., & Thiele, E. (2014). Cannabidiol (CBD) treatment for refractory epilepsy in tuberous sclerosis complex (TSC). 2.427, American Epilepsy Society Annual Meeting. www.aesnet.org

*Both studies lack appropriate research rigor for conclusive results.

Questions that Arise

- How can a state pass a law in clear violation of federal drug laws?
- How does a state prevent their conflicting drug laws from negatively impacting neighboring states?
- If a municipality does not want legal pot in their city, can they opt out of the state law?
- What does an employer do when employees with “medical” marijuana cards have a positive drug test?



FDA Process

FDA Process in place for over 100 years
Rigorous, scientific process

Dose

Efficacy

Condition

Clean and Pure

System for Recall

Drug Interactions

Pharmaceutical Companies

GW Pharmaceuticals – Epidiolex

Dravet and LGS

Second phase of three phase clinical trial

Expanded Access Programs

New York, California,
Iowa, Minnesota,
Pennsylvania, North
Carolina, Maryland

Insys Therapeutics

January 2015 – pharmacokinetic study

March/April 2015 – Phase 3
Clinical Trials on Dravet and
LGS



Research Reported

- Promising signals of efficacy and safety on 58 treatment-resistant children and young adults
- Approximately 410 children and young adults now authorized for treatment with Epidiolex®
- 20 expanded access Investigational New Drug Applications (INDs)
- Approximately 200 children now receiving Epidiolex® treatment under expanded access INDs at 11 clinical sites in the U.S.

FDA Approved Medications		CBD/"Medical" Marijuana	
VS			
Pure		May Not Be Pure	
Safe		Not Proven Safe	
Effective		No Evidence of Effectiveness	
Tested by Randomized Controlled Trials		Not Tested by Randomized Controlled Trials	
Capacity for Emergency Recall		No Capacity for Emergency Recall	
Physician Prescription Required		Physician Prescription Not Required	
Sold in Pharmacies		Sold in Marijuana Dispensaries	
Dispensed by Licensed Pharmacists		Dispensed by "Budtenders"	



Concerns with FDA-Approved CBD Studies

“Not every child is eligible to receive medication.”

“I don’t want my child to receive the placebo during the study.”


“I don’t want to be limited to one formula of CBD.”

“It’ll take too long.”

“Pharmaceutical drugs are too expensive, and marijuana is cheap.”

If CBD Legalized in Idaho

- Idaho will be in violation of Federal law
 - *Nominee for new Attorney General*
- The medical community is bypassed because it is not an FDA-approved medication
- The safety and efficacy of the product will be unknown
- The purity of the product will be unknown

- 
- Patients will have to rely on “buddenders” to advise regarding dosing the drug
 - Negative drug interactions are unknown
 - Possible side effects are unknown
 - Idaho will be forced to expand government to administer and fund a CBD program

FDA approved studies of CBD in Idaho will:

☒ Provide a method for sick Idahoans to access safe, effective medication

☒ Adhere to the FDA process instead of legislating medicine and expanding state government

☒ Allow for the compassionate care of Idahoans while adhering to Federal drug laws

Concerns from Utah

- “The law provides a false hope for families.”
- “As a state, we are recommending something we don’t know enough about.”
- “Colorado can’t meet the supply of all that want to participate.”
- “Who is liable when something goes wrong?”

Elisha Figueroa
Administrator
Governor's Office of Drug Policy
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AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, February 04, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Gubernatorial Appointment Consideration	Michael Gibson of Nampa, Idaho, was appointed to the Commission for the Blind & Visually Impaired to serve a term commencing July 1, 2014, and expiring July 1, 2017	Chairman Heider
Gubernatorial Appointment Hearing & Consideration	Travis Beck of Idaho Falls, Idaho, was appointed to the Commission for the Blind & Visually Impaired to serve a term commencing April 3, 2014, and expiring July 1, 2016	Travis Beck
Docket No. <u>16-0202-1401</u>	Rules of Emergency Medical Services (EMS) Physician Commission	Dr. Curtis Sandy, Chair
<u>RS23218</u>	Relating to Residential Care - Amending to Provide a Change in Lease does not Require Facility Licensing & to make Technical Corrections	Tamara Prisock Division Administrator
<u>RS23263</u>	Relating to Certified Family Homes - Amending to Define a Term and Make Technical Corrections. Amending to Provide Medical Foster Homes Exempt from Certification Requirements under Certain Circumstances & Make Technical Corrections"	Tamara Prisock Division Administrator

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 04, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson(Lodge), Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Lacey

**ABSENT/
EXCUSED:** None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:10 p.m.

**VOTE ON
GUBERNATORIAL
APPOINTMENT:** **Senator Tippetts** moved to send the gubernatorial appointment of Michael Gibson to the Commission for the Blind and Visually Impaired to the floor with the recommendation that he be confirmed by the Senate. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**. Senator Hagedorn will carry the appointment on the floor.

**GUBERNATORIAL
APPOINTMENT
HEARING:** **Chairman Heider** welcomed Travis Beck of Idaho Falls, who was appointed to the Commission for the Blind and Visually Impaired (Commission) to serve a term commencing April 3, 2014, and expiring July 1, 2016.

Travis Beck took the podium to outline his professional history as a legally blind individual. He said he has a good understanding of what life is like for the blind, because he has been legally blind since birth. He said he first became involved with the Commission during a summer work program at age 16. He went through the Commission's mobility and training program at age 19 and is currently a vendor with the Commission's Business Enterprise Program (BEP). He has served approximately six years on the board of the Commission.

Mr. Beck answered questions from the Committee, which centered mostly on the roadblocks and challenges a blind person encounters. **Mr. Beck** said there is no one roadblock greater than another. He said the challenges are a series of roadblocks that include schooling, training, and educating employers. **Mr. Beck** explained that a licensed BEP vendor is a designation created under the Ralph Shepherd Act, which gives priority to blind individuals to operate food facilities and vending.

**VOTE ON
GUBERNATORIAL
APPOINTMENT:** **Vice Chairman Martin** moved to send the gubernatorial appointment of Travis Beck to the Commission for the Blind and Visually Impaired to the floor with the recommendation that he be confirmed by the Senate. **Senator Lacey** seconded the motion. The motion carried by **voice vote**. **Vice Chairman Martin** will carry the appointment on the floor.

**PASSED THE
GAVEL:** Chairman Heider passed the gavel to Vice Chairman Martin for rules review.

**DOCKET NO.
16-0202-1401**

Dr. Curtis Sandy introduced himself as Chair, Emergency Medical Services (EMS) Physician Commission of Portneuf Medical Center in Pocatello, and Chair for the Idaho EMS Physicians Commission. He said the EMS Physicians Commission was formed by the passage of H 8585 during the 2006 Legislature. He explained the purpose of the EMS Physicians Commission, which is to establish standards for the scope of practice and medical supervision for licensed EMS personnel and organizations.

Dr. Sandy said **Docket No. 16-0202-1401** incorporates the latest version of the EMS Standards Manuals (see attachment 1). He outlined the changes in the rules review book and said the changes align the definition of EMS with the definition in Idaho Code § 5-1012. He said all changes are merely housekeeping updates.

Dr. Sandy asked the Committee to approve **Docket No. 16-0202-1401** and stood for questions.

MOTION:

Senator Nuxoll moved to approve **Docket No. 16-0202-1401**. **Senator Lee** seconded the motion. The motion was carried by **voice vote**.

**PASSED THE
GAVEL:**

Vice Chairman Martin passed the gavel back to Chairman Heider.

Chairman Heider invited Tamara Prisock to present the next agenda item.

RS 23218

Tamara Prisock, Administrator, Division of Licensing and Certification, Department of Health and Welfare (Department), presented **RS 23218**, which relates to residential care and amends to provide that a change in lease does not require facility licensing and to make technical corrections.

Ms. Prisock explained that changes in the lease of property on which the facility is located do not affect the actual operation of the facility or the delivery of care to the residents and should not require relicensure of the facility. She said that removing the requirements for a facility to become relicensed when there has been a change in lease will result in savings of both the facility's staff time and money and savings in the Department's staff time.

Ms. Prisock asked the Committee to send **RS 23218** to print and stood for questions.

MOTION:

Senator Tippetts moved to print **RS 23218**. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

RS 23263

Ms. Prisock presented **RS 23263**, relating to certified family homes. The proposed change in statute would exempt homes approved by the Department of Veterans Affairs (VA) as Medical Foster Homes (MFH) from state certification for the care of dependent veterans who are not receiving Medicaid. Homes that care for non-veterans in addition to veterans would still require state certification.

Ms. Prisock said MFHs that care only for veterans who do not receive Medicaid, should not be subject to inspections by both the Department and the VA. She recapped that homes that care for non-veterans in addition to veterans and homes that care for veterans receiving Medicaid would still require certification by the Department.

Ms. Prisock asked the Committee to send **RS 23263** to print and stood for questions.

Senator Schmidt asked how many entities would be affected. **Ms. Prisock** answered that the program is new to the VA. It is just getting started in the Treasure Valley and will eventually expand to other areas if it is successful. She said at this time the Department is not exempting the homes.

Senator Schmidt said he would like more information when the bill comes before the Committee. **Ms. Prisock** deferred to Cindy Bahora, Social Worker at the Boise VA Medical Center and MFH Coordinator, who was in the audience.

Ms. Bahora said the VA is hoping at the outset to have 15 to 20 homes, some of which would be certified family homes and some not.

Chairman Heider asked if these homes will be supervised by both the VA and the Department or if the VA has priority. **Ms. Bahora** said the VA would not subject a facility to state certification after the home has been approved by the VA as a MFH, provided it is caring only for veterans who do not receive Medicaid.

MOTION:

Senator Hagedorn moved to print **RS 23263**. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**.

ADJOURNED:

There being no further business, **Chairman Heider** adjourned the meeting at 3:35 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant



STATE OF IDAHO

EMS PHYSICIAN COMMISSION

STANDARDS MANUAL

Authority:

Idaho Code § 56-1013A, § 56-1016, and § 56-1017(1)

Rules for EMS Physician Commission Idaho Administrative Procedures Act 16.02.02

Edition 2015-1



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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I. DEFINITIONS.

As promulgated by and in addition to the applicable definitions in Section 56-1012, Idaho Code, and IDAPA 16.01.02, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services," the following terms are used in this manual as defined below:

Advanced Emergency Medical Technician (AEMT). A person who holds a current active license issued by the EMS Bureau at the Advanced Emergency Medical level and is in good standing with no restriction upon, or actions taken against, his license.

Affiliation. The recognition of an individual as a member or employee.

Bureau of Emergency Medical Services and Preparedness. The Bureau of Emergency Medical Services and Preparedness of the Idaho Department of Health and Welfare, hereafter referred to as "the Bureau."

Contemporaneous. Originating, existing, or occurring during the same period of time.

Credentialed EMS Personnel. Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician.

Credentialing. The local process by which licensed EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice.

Critical Care Paramedic. A person who holds a current active license issued by the Bureau at the Paramedic or Emergency Medical Technician-Paramedic level and has successfully completed training objectives as set forth in the Critical Care Transport Curriculum Guide of the Bureau and who possesses a current active credential to provide Critical Care.

Critical Care Transport. The transportation of a patient with continuous care, monitoring, medication, or procedures requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer.

Designated Clinician. A licensed Physician Assistant (PA) or Nurse Practitioner designated by the EMS medical director, hospital supervising physician, or medical clinic supervising physician who is responsible for direct (on-line) medical supervision of licensed EMS personnel in the temporary absence of the EMS medical director.

Direct (On-Line) Supervision. Contemporaneous instructions and directives about a specific patient encounter provided by a physician or designated clinician to licensed EMS personnel who are providing medical care.

Emergency Medical Services (EMS). Under Section 56-1012(12), Idaho Code, emergency medical services or EMS is aid rendered by an individual or group of individuals who do the following:

- a. Respond to a perceived need for medical care in order to prevent loss of life, aggravation of physiological or psychological illness, or injury;
- b. Are prepared to provide interventions that are within the scope of practice as defined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, "Rules of the Idaho Emergency Medical Services (EMS) Physician Commission";
- c. Use an alerting mechanism to initiate a response to requests for medical care; and
- d. Offer, advertise, or attempt to respond as described in Section 56-1012(12), (a) through (c), Idaho Code.
- e. Aid rendered by a ski patroller, as described in Section 54-1804(1)(h), Idaho Code, is not EMS.

Emergency Medical Services Physician Commission. The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code, hereafter referred to as "the Commission."

Emergency Medical Responder (EMR). A person who holds a current active license issued by the Bureau at the First Responder or Emergency Medical Responder level and is in good standing with no restriction upon, or actions taken against, his license.

Emergency Medical Technician (EMT). A person who holds a current active license issued by the Bureau at the Emergency Medical Technician or Emergency Medical Technician-Basic level and is in good standing with no restriction upon, or actions taken against, his license.

EMS Agency. An organization licensed by the Bureau to provide emergency medical services in Idaho.

EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency.

Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code.

Hospital Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a hospital.

Indirect (Off-Line) Supervision. The medical oversight provided by a physician to licensed EMS personnel who are providing medical care. The components of medical supervision include EMS system design, education, quality management, patient care guidelines, medical policies, and compliance.

License. A license issued by the Bureau to an individual for a specified period of time indicating that minimum standards corresponding to one (1) of several levels of EMS proficiency have been met.

Licensed EMS Personnel. Individuals who possess a valid license issued by the Bureau.

Medical Clinic. A place devoted primarily to the maintenance and operation of facilities for outpatient medical, surgical, and emergency care of acute and chronic conditions or injury.

Medical Clinic Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a medical clinic.

Medical Supervision. The advice and direction provided by a physician, or under the direction of a physician, to licensed EMS personnel who are providing medical care, including direct and indirect supervision.

Medical Supervision Plan (MSP). The written document describing the provisions for medical supervision of licensed EMS personnel.

Nurse Practitioner. An Advanced Practice Professional Nurse, licensed in the category of Nurse Practitioner, as defined in IDAPA 23.01.01, "Rules of the Idaho Board of Nursing."

Out-of-hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of emergency medical services may take place.

Paramedic. A person who holds a current active license issued by the Bureau at the Paramedic or Emergency Medical Technician-Paramedic level and is in good standing with no restriction upon, or actions taken against, his license.

Physician. A person who holds a current active license issued by the Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restriction upon, or actions taken against, his license.

Physician Assistant. A person who meets all the applicable requirements to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants."

II. EMS Physician Commission Standards Manual Authority

Idaho Code 56-1013A(1) empowers the EMS Physician Commission with statutory authority to establish standards for scope of practice and medical supervision for licensed personnel, air medical, ambulance, and non-transport agencies licensed by the Bureau. Idaho Code 56-1017(1) specifically authorizes and directs the Commission to adopt appropriate rules defining the allowable scope of practice and acts and duties which can be performed by persons licensed by the department and the required level of supervision by a licensed physician.

IDAPA 16.02.02, "Rules of the EMS Physician Commission," Section 004 incorporate this EMS Physician Commission Standards Manual by reference. The purposes of this EMS Physician Commission Standards Manual are to establish the scope of practice of licensed EMS personnel and to specify the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS licensure.

III. EMS Personnel Authority to Act

To provide emergency medical services, EMS licensed personnel must comply with Idaho Code and IDAPA 16.02.02, "Rules of the EMS Physician Commission." The policies of the EMS Physician Commission are documented in this Standards Manual.

Licensed EMS personnel who are representing an Idaho EMS agency and who possess a valid credential issued by that agency's EMS medical director may act and provide services in the out-of-hospital setting under the following conditions:

1. When participating in a planned deployment of personnel resources approved by the EMS medical director; or
2. When administering first aid or emergency medical attention as a "Good Samaritan" and without expectation of remuneration in accordance with Idaho Code 5-330 or 5-331 in a manner approved by the EMS medical director; or
3. When participating in a training program approved by the Bureau or the EMS medical director.
4. When on duty, visibly display at all times identification specifying name and level of EMS licensure.

In addition, licensed EMS personnel may only provide out-of-hospital care when:

1. The patient care does not exceed the scope of practice as defined by this Standards Manual; and
2. Licensed EMS personnel have been trained, based on curricula or specialized training approved according to IDAPA 16.02.03, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services;" and
3. The patient care does not exceed the scope of practice approved by their EMS medical director and does not include assessments or interventions that have been specifically prohibited by their EMS medical director.

Licensed EMS personnel who are representing a hospital or medical clinic and who possess a valid credential issued by the hospital or medical clinic supervising physician may act and provide services in the hospital and medical clinic setting under the following conditions:

1. When participating in a planned deployment of personnel resources approved by the hospital or medical clinic supervising physician; or
2. When administering first aid or emergency medical attention as a "Good Samaritan" and without expectation of remuneration in accordance with Idaho Code 5-330 or 5-331 in a manner approved by the hospital or medical clinic supervising physician; or
3. When participating in a training program approved by the Bureau or the hospital or medical clinic supervising physician.

In addition, licensed EMS personnel may only provide hospital and medical clinic care when:

1. Licensed EMS personnel have been trained, based on curricula or specialized training approved according to IDAPA 16.02.03, Idaho Department of Health and Welfare, "Rules Governing Emergency Medical Services," or additional training approved by the hospital or medical clinic supervising physician and
2. The patient care does not exceed the scope of practice approved by their hospital or medical clinic supervising physician and does not include assessments or interventions that have been specifically prohibited by their hospital or medical clinic supervising physician.

IV. OUT-OF-HOSPITAL SUPERVISION

All Idaho-licensed EMS agencies, including hospital-based EMS agencies, must comply with the requirements described in this section. Hospital-based EMS agencies must comply with both the requirements described in this section and with the hospital and clinic supervision requirements described later in this Standards Manual when their licensed EMS personnel also have patient care duties in the hospital or clinic setting.

EMS Medical Director Qualifications, Authority and Responsibility.

In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director.

1. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency.
2. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director.

The EMS medical director will have a written agreement with the EMS agency(s) that includes the following elements:

1. Identification of the EMS agency(s) for which he provides medical supervision.

2. Acknowledgement of the authority of the EMS medical director as established in Idaho statute and IDAPA 16.02.02, "Rules of the EMS Physician Commission."
3. An effective date.
4. An expiration date or a provision for automatic renewal upon mutual agreement.
5. Assurance of EMS medical director access to relevant agency, hospital, or medical clinic records as permitted or required by statute to ensure responsible medical supervision of licensed EMS personnel.

The EMS medical director will provide the Bureau with documentation of the written agreement annually or upon request.

The EMS medical director must:

1. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel.
2. Obtain and maintain knowledge of the contemporary design and operation of EMS systems.
3. Obtain and maintain knowledge of Idaho EMS laws, regulations and standards manuals.
4. The EMS medical director shall demonstrate appropriate training and/or expertise in adult and pediatric emergency medical services.
5. The EMS medical director for an air medical agency, in addition to the above requirements, must have training and experience in emergency medicine or critical care and have training in air ambulance operations that include flight physiology, stressors of flight, and air medical resource management.

The EMS medical director is authorized to:

1. Provide explicit approval for licensed EMS personnel under his supervision to provide medical care. Licensed EMS personnel may not provide medical care without the explicit approval of an EMS medical director.
2. Credential licensed EMS personnel under his supervision with a scope of practice. This scope of practice may be limited relative to the scope of practice authorized by the Commission and may not exceed the scope of practice established by the Commission.
3. Restrict the scope of practice of licensed EMS personnel under his supervision and withdraw approval of licensed EMS personnel to provide services when such personnel fail to meet or maintain proficiencies established by the EMS medical director or the Idaho EMS Bureau.
 - a. Such restriction or withdrawal of approval must be reported in writing within fifteen (15) days of the action to the Bureau in accordance with Section 39-1393, Idaho Code.

The EMS medical director is responsible for:

1. Approving the planned deployment of personnel resources.
2. Approving the manner in which licensed EMS personnel administer first aid or emergency medical attention as a “Good Samaritan” in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration.
3. Documenting the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual.
4. Documenting that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment.
5. Developing and implementing a program for continuous assessment and improvement of services by licensed EMS personnel under their supervision.
6. Reviewing and updating protocols, policies, and procedures at least every two (2) years.
7. Developing, implementing and overseeing a Medical Supervision Plan, as defined in this Standards Manual.
8. Collaborating with other EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians to ensure EMS agencies and licensed EMS personnel have protocols, standards of care, and procedures that are consistent and compatible with one another.
9. Designating other physicians to supervise licensed EMS personnel in the temporary absence of the EMS medical director.
10. Designating Physician Assistants and Nurse Practitioners to serve as designated clinicians, as defined in this Standards Manual.

Direct Medical Supervision by Physician Assistants and Nurse Practitioners.

The EMS medical director can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct (on-line) medical supervision of licensed EMS personnel. Such designated clinicians may only provide direct medical supervision when a designated physician is not present in the anticipated receiving health care facility. The following conditions must also be satisfied:

1. A written agreement between the designated Nurse Practitioner and the EMS medical director which describes the role and responsibilities of the designated Nurse Practitioner is required.
2. A written agreement between the designated PA and the EMS medical director which describes the role and responsibilities of the designated PA related to supervision of EMS personnel is required.
3. Designated clinicians must possess and be familiar with the Medical Supervision Plan, as defined in this Standards Manual, protocols, standing orders, and standard operating procedures authorized by the EMS medical director.

4. The physician supervising the PA, as defined in IDAPA 22.01.03, Idaho Department of Health and Welfare, "Rules for the Licensure of Physician Assistants," must authorize the designated PA to provide direct (on-line) supervision.

Provisions for direct medical supervision by designated clinicians must be documented in the Medical Supervision Plan.

Medical Supervision Plan for the Out-Of-Hospital Setting.

The medical supervision of licensed EMS personnel must be provided in accordance with a documented Medical Supervision Plan (MSP) that includes direct, indirect, on-scene, educational, and proficiency standards components. The EMS medical director is responsible for developing, implementing, and overseeing the MSP. However, non-physicians can assist the EMS medical director with the indirect medical supervision of licensed EMS personnel. The EMS medical director will submit the MSP to the Bureau upon request by the Bureau or the Commission. Medical Supervision Plans must be submitted within thirty (30) days of request. The Bureau must be notified of any changes in the MSP, including changes in designated clinicians, within thirty (30) days of the change(s).

At a minimum, the MSP must consist of the following elements:

A. Credentialing of licensed EMS personnel.

Credentialing is an EMS agency process by which licensed EMS personnel are authorized by the EMS medical director to provide medical care in accordance with a scope of practice that is established by the EMS medical director. The process for credentialing licensed EMS personnel is an extension of the "affiliating" of personnel and is consistent with contemporary EMS system design.

The process for credentialing will include the following:

1. Verification of Bureau licensure;
2. Affiliation to the EMS agency;
3. Review of the qualifications and proficiencies of the EMS provider, and all other EMS agency, hospital, and medical clinic affiliations.
4. Completion of an EMS agency orientation, as prescribed by the EMS agency, that includes:
 - a. EMS agency policies;
 - b. EMS agency procedures;
 - c. Medical treatment protocols;
 - d. Radio communications procedures;
 - e. Hospital/facility destination policies;
 - f. Other unique system features.

Upon successful completion of the credentialing process, the EMS medical director may issue the EMS provider with a card, certificate, or other document which indicates explicit approval to provide patient care and specifically authorizes a scope of practice for the EMS provider.

- This credential should include a specific expiration date which may be the same date of expiration as the Bureau license.
- This credential will be sufficient evidence of “affiliation” for his or her license or renewal by the Bureau, if the dates are inclusive of the licensure period and the credential has not been withdrawn by the EMS medical director.

B. Indirect (off-line) medical supervision.

Indirect (off-line) supervision will include all of the following:

1. Written standing orders and treatment protocols for both adult and pediatric patients including direct (on-line) supervision criteria;
2. Description of authorized optional psychomotor skills and patient care interventions, as defined by the Commission;
3. Initial and continuing education in addition to those required by the Bureau;
4. Methods of assessment and improvement;
5. Periodic assessment of psychomotor skill proficiency;
6. Provisions for medical supervision of and defining the patient care provided by licensed EMS personnel who are present for a multiple or mass casualty incident, disaster response, or other significant event involving response of licensed EMS personnel;
7. Defining the response when licensed EMS personnel discover a need for EMS while not on duty;
8. The credentialing of licensed EMS personnel for emergency response;
9. The appropriate level of emergency response based upon dispatch information provided by the designated Public Safety Answering Point(s);
10. Triage, treatment, and transport guidelines;
11. Scene management for multiple EMS agencies anticipated to be on scene concurrently;
12. Criteria for determination of patient destination;
13. Criteria for utilization of air medical services in accordance with IDAPA 16.01.03, Idaho Department of Health and Welfare, “Emergency Medical Services (EMS) – Agency Licensing Requirements,” Section 700-799;
14. Policies and protocols for patient refusal, “treat and release”, advanced directives by patients and physicians, determination of death, termination of resuscitation and other predictable patient non-transport scenarios;
15. Criteria for cancellation or modification of EMS response;
16. Equipment authorized for patient care;

17. Medical communications guidelines; and
18. Methods and elements of documentation of services provided by licensed EMS personnel.
19. Policies and protocols for the identification, treatment and transport of patients with ST-elevation myocardial infarction to ensure timely re-perfusion therapy.
20. Policy for recognition and utilization of bystander providers that are not credentialed by the local EMS system.

C. Direct (on-line) medical supervision.

Direct supervision may be accomplished by concurrent communication with the EMS medical director, other physicians designated by the EMS medical director, or designated clinicians, who must be available twenty-four (24) hours a day seven (7) days a week. Provisions for direct supervision, including on-scene supervision, will be documented in the MSP which shall identify designated clinicians.

The EMS medical director will develop and implement procedures in the event of on-scene supervision by:

1. The EMS medical director or other physician(s) designated by the EMS medical director;
2. A physician with a pre-existing relationship with the patient; and
3. A physician with no pre-existing relationship with the patient who may or may not be present for the duration of treatment on scene or transportation.

Direct supervision of licensed EMS personnel by other persons is prohibited except in the manner described in the MSP.

Designated on-line physicians and clinicians shall have appropriate training and/or expertise in adult and pediatric emergency care.

D. Standards of supervision and training for students of state-approved training programs.

The EMS medical director, in collaboration with the course medical director or course coordinator, will define standards of supervision and training for students of state-approved training programs, who have been placed for clinical practice and training. These standards will be defined, identified, and documented in the MSP.

V. HOSPITAL AND MEDICAL CLINIC SUPERVISION

Licensed EMS Personnel Responsibilities.

The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic must:

1. When on duty, visibly display at all times identification specifying their level of EMS licensure.
2. Report such employment or utilization to the Bureau within thirty (30) days of engaging in such activity.

Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician or designated clinicians, as defined in this Standards Manual.

Hospital Supervising Physician and Medical Clinic Supervising Physician Qualifications, Authority and Responsibility.

In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician.

1. The hospital or medical clinic administration must designate a physician for the medical supervision of licensed EMS personnel employed or utilized in the hospital or medical clinic.
2. The hospital supervising physician or medical clinic supervising physician can designate other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician.
3. Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician or designated clinicians, who are defined in this Standards Manual.

The hospital supervising physician and medical clinic supervising physician must:

1. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel.
2. Obtain and maintain knowledge of the contemporary design and operation of EMS systems.
3. Obtain and maintain knowledge of Idaho EMS laws, regulations and standards manuals.

The hospital supervising physician and medical clinic supervising physician are authorized to:

1. Provide explicit approval for licensed EMS personnel under his supervision to provide medical care. Licensed EMS personnel may not provide medical care without the explicit approval of a hospital supervising physician or medical clinic supervising physician.

2. Credential licensed EMS personnel under his supervision with a scope of practice. This scope of practice may be limited relative to the scope of practice authorized by the Commission. If the authorized scope of practice exceeds the out-of-hospital scope of practice established by the Commission, the hospital supervising physician and/or medical clinic supervising physician must approve additional training to ensure competency in the expanded scope of practice. The Commission recognizes that hospital and medical clinic policies, state rules and the local community standard of care will influence the specific elements of any expanded scope of practice and the development of additional local oversight requirements.
3. Restrict the scope of practice of licensed EMS personnel under his supervision and to withdraw approval of licensed EMS personnel to provide services when such personnel fail to meet or maintain proficiencies established by the hospital supervising physician or medical clinic supervising physician or the Bureau.
 - o Such restriction or withdrawal of approval must be reported in writing within fifteen (15) days of the action to the Bureau in accordance with Section 39-1393, Idaho Code.

The hospital supervising physician and medical clinic supervising physician are responsible for:

1. Approving the planned deployment of personnel resources.
2. Approving the manner in which licensed EMS personnel administer first aid or emergency medical attention as a "Good Samaritan" in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration.
3. Approving additional training when the local scope of practice exceeds the out-of-hospital scope of practice established by the Commission.
4. Documenting the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual.
5. Documenting that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment.
6. Developing, implementing and overseeing a Medical Supervision Plan, as defined in this Standards Manual.
7. Collaborating with other EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians to ensure EMS agencies and licensed EMS personnel have protocols, standards of care and procedures that are consistent and compatible with one another.
8. Designating other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician.
9. Designating Physician Assistants and Nurse Practitioners to serve as designated clinicians, as defined in this Standards Manual.

Direct Medical Supervision by Physician Assistants and Nurse Practitioners.

The hospital supervising physician or medical clinic supervising physician can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct (on-line) medical supervision of licensed EMS personnel under the following conditions:

1. A written agreement between the designated Nurse Practitioner and the hospital supervising physician or medical clinic supervising physician which describes the role and responsibilities of the designated Nurse Practitioner is required,
2. A written agreement between the designated PA and the hospital supervising physician or medical clinic supervising physician which describes the role and responsibilities of the designated PA related to supervision of EMS personnel is required,
3. Designated clinicians must possess and be familiar with the Medical Supervision Plan, as defined in this Standards Manual, protocols, standing orders, and standard operating procedures authorized by the hospital supervising physician or medical clinic supervising physician.
4. The physician supervising the PA, as defined in IDAPA 22.01.03, "Rules for the Licensure of Physician Assistants," must authorize the designated PA to provide direct (on-line) supervision.

Provisions for direct medical supervision by designated clinicians must be documented in the Medical Supervision Plan.

Medical Supervision Plan for the Hospital and Medical Clinic Settings.

The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan (MSP). The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the MSP.

The MSP will include:

1. A credentialing process for licensed EMS personnel as defined by the hospital or medical clinic.
2. A current written description of acts and duties authorized by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel.
3. The hospital or medical clinic will submit such descriptions upon request of the Commission or the Bureau.
4. Provisions for direct medical supervision by designated clinicians and the identification of designated clinicians.

VI. BUREAU RESPONSIBILITIES.

The Bureau will provide:

1. Technical assistance to medical directors, hospital supervising physicians, medical clinic supervising physicians, and their administrators to develop appropriate Medical Supervision Plans.
2. The Commission with EMS agency Medical Supervision Plans upon request.
3. The Commission with the identification of EMS medical directors and their designated clinicians annually and upon request.

VII. EMS PHYSICIAN COMMISSION RESPONSIBILITIES.

The Commission will provide interpretation of the Rules of the Commission.

VIII. IDAHO AUTHORIZED SCOPE OF PRACTICE.

The Commission has approved the Scope of Practice for licensed EMS personnel, which is articulated in Appendix A. Appendix A lists specific psychomotor skills and patient care interventions and indicates the level of EMS licensure that may perform each skill or intervention. The EMS Medical Director, Hospital Supervising Physician, or Medical Clinic Supervising Physician must oversee a process to verify competency in all credentialed skills and interventions. The effective date of this Scope of Practice will be July 1, 2015.

It must be noted that not everyone is currently operating at the levels indicated by Xs in Appendix A and that it is only upon completion of required education, competency assessment, and endorsement or permission by their medical director that a provider can perform the procedures.

Appendix A implicitly defines both a “floor” and “ceiling” for each level of EMS licensure. Licensed EMS personnel must receive training and demonstrate competency in each skill and intervention that lies within their “floor.” Training for skills and interventions within the “floor” is based on curricula or specialized training approved according to IDAPA 16.02.03, Idaho Department of Health and Welfare, “Rules Governing Emergency Medical Services.” Training and competency in skills and interventions within the “floor” are verified by examination and state EMS licensure according to IDAPA 16.02.03, Idaho Department of Health and Welfare, “Rules Governing Emergency Medical Services” and IDAPA 16.01.07, Idaho Department of Health and Welfare, “Emergency Medical Services (EMS) – Personnel Licensing Requirements.” Skills and interventions designated by an “X” in Appendix A are included in the “floor” for the specified level of EMS licensure.

Skills and interventions designated by “OM” in Appendix A may be authorized by the EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician and are considered optional. These skills and interventions lie between the “floor” and “ceiling” of the specified level of EMS licensure. The EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician must ensure that licensed EMS personnel

receive appropriate initial and continuing training for optional skills and interventions. In addition, the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician must take an active role in verifying competency in optional skills and interventions since state EMS licensing will not address optional skills or interventions. Agencies must provide the minimum equipment required for their authorized OMs.

When an EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician desires to incorporate an OM, they must:

1. Report patient care response data to the Idaho Prehospital Electronic Record Collection System (PERCS) directly or by way of an Idaho validated export from a National EMS Information System (NEMSIS) compliant software application.
 - a. If an agency has not been able to obtain PERCS validation, they must report optional module usage on their annual agency renewal application. This method of reporting shall expire June 30, 2016.
2. Submit an addendum to their medical supervision plan to the Bureau that indicates which OM(s) they want to adopt.
3. Submit verification of credentialing to the Bureau prior to utilization of OM skills or interventions.

Psychomotor skills and patient care interventions that are not designated by either an “X” or “OM” in Appendix A fall outside the Commission’s established Scope of Practice for the specified level of EMS licensure and may not be performed by licensed EMS personnel at that level in the out-of-hospital setting. As such, Appendix A defines the “ceiling” for the specified level of EMS licensure.

Appendix A includes a CC Skills (Critical Care Skills) column that designates optional psychomotor skills and patient care interventions that may be performed by a Paramedic who receives additional training in critical care transport and who is appropriately credentialed by the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician. This formal training program must meet or exceed the applicable objectives of the curriculum approved according to IDAPA 16.02.03, Idaho Department of Health and Welfare, “Rules Governing Emergency Medical Services.” Completion of the entire curriculum is not required. Curriculum objectives are currently listed in the “Idaho EMS Critical Care Transport Curriculum Guide.” The EMS Medical Director, Hospital Supervising Physician and/or Medical Clinic Supervising Physician must ensure that licensed EMS personnel receive appropriate initial and continuing training for optional skills and interventions. In addition, the EMS Medical Director, Hospital Supervising Physician or Medical Clinic Supervising Physician must take an active role in verifying competency in optional skills and interventions since state EMS licensing will not address optional skills and interventions.

The Commission has created additional requirements for certain psychomotor skills and patient care interventions that, if done improperly, represent a significant hazard to the patient. Additional standards may include but are not limited to on-line medical direction prior to performance of the skill or intervention, completion of specified training prior to credentialing,

required elements for Patient Care Report documentation, required elements for performance assessment and improvement and/or compliance with a state-wide protocol or guideline. See Appendices B through C. Skills and interventions with additional requirements are designated in Appendix A by a 1, 2, 3, 4, 5, etc. alongside the “X” or “OM”.

Emergency Medical Responder (EMR)

The primary focus of the Emergency Medical Responder, which prior to July 1, 2009 was known as a certified First Responder, is to initiate immediate lifesaving care to critical patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and to assist higher level personnel at the scene and during transport. Emergency Medical Responders function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Responders perform basic interventions with minimal equipment.

Description of the Profession

The Emergency Medical Responder’s scope of practice includes simple skills focused on lifesaving interventions for critical patients. Typically, the Emergency Medical Responder renders on-scene emergency care while awaiting additional EMS response and may serve as part of the transporting crew, but not as the primary care giver.

In many communities, Emergency Medical Responders provide a mechanism to increase the likelihood that trained personnel and lifesaving equipment can be rapidly deployed to serious emergencies. In all cases, Emergency Medical Responders are part of a tiered response system. Emergency Medical Responders work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Emergency Medical Responder’s scope of practice includes simple, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, the Emergency Medical Responder provides care designed to minimize secondary injury and comfort the patient and family while awaiting additional EMS resources.

A major difference between the lay person and the Emergency Medical Responder is the “duty to act” as part of an organized EMS response.

In some systems, Emergency Medical Responders serve as a part of the crew on transporting EMS units; however, the Emergency Medical Responder is not intended to be the highest level caregiver in such situations. They must function with an EMT or higher level personnel during the transportation of emergency patients. The scope of practice model of an Emergency Medical Responder is limited to simple skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight.

After initiating care, the Emergency Medical Responder transfers care to higher level personnel. The Emergency Medical Responder serves as part of an EMS response system that ensures a progressive increase in the level of assessment and care.

Emergency Medical Technician (EMT)

The primary focus of the Emergency Medical Technician is to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Technicians perform interventions with the basic equipment typically found on an ambulance. The Emergency Medical Technician is a link from the scene to the emergency health care system.

Description of the Profession

The Emergency Medical Technician's scope of practice includes basic skills focused on the acute management and transportation of critical and emergent patients. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

In many communities Emergency Medical Technicians provide a large portion of the prehospital care. In some jurisdictions, especially rural areas, Emergency Medical Technicians provide the highest level of prehospital care. Emergency Medical Technicians work alongside other EMS and health care professionals as an integral part of the emergency care team.

Emergency Medical Technicians' scope of practice includes basic, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, Emergency Medical Technicians provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.

An Emergency Medical Technician's knowledge, skills, and abilities are acquired through formal education and training. The Emergency Medical Technician has the knowledge of, and is expected to be competent in, all of the skills of the Emergency Medical Responder. A major difference between the Emergency Medical Responder and the Emergency Medical Technician is the knowledge and skills necessary to provide medical transportation of emergency patients.

The Emergency Medical Technician level is the minimum licensure level for personnel transporting patients in ambulances. The scope of practice is limited to basic skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight and limited training.

The Emergency Medical Technician transports all emergency patients to an appropriate medical facility. The Emergency Medical Technician is not prepared to make decisions independently regarding the appropriate disposition of patients. The Emergency Medical Technician serves as part of an EMS response system, assuring a progressive increase in the level of assessment and care. The Emergency Medical Technician may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

In addition to emergency response, Emergency Medical Technicians often perform medical transport services of patients requiring care within their scope of practice.

Advanced Emergency Medical Technician (AEMT)

The primary focus of the Advanced Emergency Medical Technician is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Advanced Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Advanced Emergency Medical Technicians perform interventions with the basic and advanced equipment typically found on an ambulance. The Advanced Emergency Medical Technician is a link from the scene to the emergency health care system.

Description of the Profession

The Advanced Emergency Medical Technician's scope of practice includes basic and limited advanced skills focused on the acute management and transportation of critical and emergent patients. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

For many communities, Advanced Emergency Medical Technicians provide an option to provide high benefit, lower risk advanced skills for systems that cannot support or justify Paramedic level care. This is frequently the case in rural and volunteer systems. In some jurisdictions, Advanced Emergency Medical Technicians are the highest level of prehospital care. In communities which utilize emergency medical dispatch systems, Advanced Emergency Medical Technicians may function as part of a tiered response system. In all cases, Advanced Emergency Medical Technicians work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Advanced Emergency Medical Technician's scope of practice includes basic and limited advanced interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on assessment findings. Additionally, Advanced Emergency Medical Technicians provide care to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an emergency care facility.

The Advanced Emergency Medical Technician's knowledge, skills, and abilities are acquired through formal education and training. The Advanced Emergency Medical Technician has the knowledge associated with, and is expected to be competent in, all of the skills of the Emergency Medical Responder and Emergency Medical Technician. The major difference between the Advanced Emergency Medical Technician and the Emergency Medical Technician is the ability to perform limited advanced skills for emergency patients.

The Advanced Emergency Medical Technician is the minimum licensure level for patients requiring limited advanced care at the scene or during transportation. The scope of practice is limited to lower risk, high benefit advanced skills that are effective and can be performed safely

in an out-of-hospital setting with medical oversight and limited training.

The Advanced Emergency Medical Technician transports all emergency patients to an appropriate medical facility. The Advanced Emergency Medical Technician is not prepared to independently make decisions regarding the disposition of patients. The Advanced Emergency Medical Technician serves as part of an EMS response system assuring a progressive increase in the level of assessment and care. The Advanced Emergency Medical Technician may make destination decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

In addition to emergency response, Advanced Emergency Medical Technicians often perform medical transport services of patients requiring care within their scope of practice.

Those AEMTs whose licensure is based on the Intermediate 85 curriculum and who have chosen not to complete either the EMT-2011 or the AEMT-2011 transition are expected to be competent in all the skills of the EMR and EMT with the exception of Pulse Oximetry, ATV non-intubated, aspirin, epi-auto injector, atropine sulfate & 2-Pralidoxime chloride auto-injector.

Paramedic

The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The Paramedic is a link from the scene into the health care system.

Description of the Profession

The Paramedic's scope of practice includes basic and advanced skills focused on the acute management and transportation of the broad range of patients who access the emergency medical system. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.

In some communities, Paramedics provide a large portion of the prehospital care and represent the highest level of prehospital care. In communities that utilize emergency medical dispatch systems, Paramedics may be part of a tiered response system. In all cases, Paramedics work alongside other EMS and health care professionals as an integral part of the emergency care team.

The Paramedic's scope of practice includes invasive and pharmacological interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies. Emergency care is based on an advanced assessment and the formulation of a field impression. The Paramedic provides care designed to minimize secondary injury and provide comfort to the patient and family while transporting the patient to an appropriate health care

facility.

The Paramedic has knowledge, skills, and abilities developed by appropriate formal education and training. The Paramedic has the knowledge associated with, and is expected to be competent in, all of the skills of the Emergency Medical Responder, Emergency Medical Technician, and Advanced Emergency Medical Technician. The major difference between the Paramedic and the Advanced Emergency Medical Technician is the ability to perform a broader range of advanced skills. These skills carry a greater risk for the patient if improperly or inappropriately performed, are more difficult to attain and maintain competency in, and require significant background knowledge in basic and applied sciences.

The Paramedic is the minimum licensure level for patients requiring the full range of advanced out-of-hospital care. The scope of practice is limited to advanced skills that are effective and can be performed safely in an out-of-hospital setting with medical oversight.

The Paramedic transports all emergency patients to an appropriate medical facility. The Paramedic serves as part of an EMS response system, ensuring a progressive increase in the level of assessment and care. The Paramedic may make treat and release decisions in collaboration with medical oversight. The principal disposition of the patient encounter will result in the direct delivery of the patient to an acute care facility.

In addition to emergency response, Paramedics often perform medical transport services of patients requiring care within their scope of practice.

IX. EMS Proficiency and Performance Assessment Requirement.

Additional performance assessment requirements exist for advanced airway management including all intubation attempts and placements by any personnel affiliated with the EMS agency. The responsibility of the EMS medical director includes implementation of these requirements and EMS personnel compliance pursuant to IDAPA 16.02.02.300.05 and .06. The required data elements to be supplied by every EMS provider who attempts advanced airway management will be defined by the EMS Physician Commission. EMS providers will electronically submit the required data elements directly to the EMS Physician Commission starting January 1, 2010, in a manner established by the EMS Physician Commission. EMS providers will submit the required data elements contemporaneously with the completion of their patient care documentation. In the interest of evaluating aggregate performance, the EMS Physician Commission will compile and supply the EMS medical director with submitted data elements.

X. Idaho EMS Physician Commission Contact Information

EMSPhysiciancomm@dhw.idaho.gov

www.emspc.dhw.idaho.gov

Call Toll Free: 1-877-554-3367

Idaho EMS Physician Commission
2224 W. Old Penitentiary Road
PO Box 83720
Boise, Idaho 83720-0036
(208) 334-4000
Fax (208) 334-4015

XI. Idaho Bureau of EMS and Preparedness Contact Information

IdahoEMS@dhw.idaho.gov

www.idahoems.org

Call Toll Free: 1-877-554-3367

2224 W. Old Penitentiary Road
PO Box 83720
Boise, ID 83720-0036
(208) 334-4000
Fax (208) 334-4015

AIRWAY / VENTILATION / OXYGENATION		
1	Airway – Nasal	X
2	Airway – Oral	X
3	Bag-Valve-Mask (BVM)	X
4	Cricoid Pressure (Sellick)	X
5	Finger Sweep	X
6	Head-tilt/chin-lift	X
7	Jaw-thrust	X
8	Jaw-thrust - Modified (trauma)	OM
9	Modified Chin Lift	X
10	Mouth-to-Barrier	X
11	Mouth-to-Mask	X
12	Mouth-to-Mouth	X
13	Mouth-to-Nose	X
14	Mouth-to-Stoma	X
15	Obstruction – Manual	X
16	Oxygen Therapy – Humidifiers	X
17	Oxygen Therapy – Nasal Cannula	X
18	Oxygen Therapy – Non-rebreather Mask	X
19	Oxygen Therapy – Partial Rebreather Mask	X
20	Oxygen Therapy – Simple Face Mask	X
21	Oxygen Therapy – Venturi Mask	X
22	Suctioning – Upper Airway	X
CARDIOVASCULAR / CIRCULATION		
23	Cardiopulmonary Resuscitation (CPR)	X
25	Defibrillation – Automated / Semi-Automated	X
26	Hemorrhage Control – Direct Pressure	X
27	Hemorrhage Control - Dressing	X
28	Hemorrhage Control – Tourniquet	2,OM
IMMOBILIZATION		
29		
30	Cervical Stabilization – Cervical Collar	2,OM
31	Spinal Immobilization – Long Board	2,OM
32	Cervical Stabilization – Manual	X
33	Spinal Immobilization – Seated Patient (KED, etc.)	2,OM
34	Extremity Stabilization - Manual	X
35	Extremity Splinting	2,OM
TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
36	Auto-Injector	X
37	Intramuscular (IM)	2,OM
MISCELLANEOUS		
38		
39	Assisted Childbirth Delivery - Normal	X
40	Blood Pressure – Manual	X
41	Emergency Moves for Endangered Patients	X
42	Taser Barb Removal	OM
MEDICATION FORMULARY		
43		
44	Epinephrine (Adrenalin)	2,4,OM
45	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	5X
46	Oxygen	X
47		
48	Vaccinations - at the request of the public health district if credentialed in IM administration	5,OM

Education based on Idaho Standard Curriculum (ISC) which was based on National Standard Curricula	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
Just In Time Training	5

Added: Vaccinations, line 48

AIRWAY / VENTILATION / OXYGENATION		
49	Airway – Oral	X
50	Bag-Valve-Mask (BVM)	X
51	Cricoid Pressure (Sellick)	X
52	Finger Sweep	X
53	Head-tilt/chin-lift	X
54	Jaw-thrust	X
55	Jaw-thrust - Modified (trauma)	OM
56	Modified Chin Lift	X
57	Mouth-to-Barrier	X
58	Mouth-to-Mask	X
59	Mouth-to-Mouth	X
60	Mouth-to-Nose	X
61	Mouth-to-Stoma	X
62	Obstruction – Manual	X
63	Oxygen Therapy – Nasal Cannula	X
64	Oxygen Therapy – Non-rebreather Mask	X
65	Suctioning – Upper Airway	X
CARDIOVASCULAR / CIRCULATION		
67	Cardiopulmonary Resuscitation (CPR)	X
68	Defibrillation – Automated / Semi-Automated	X
69	Hemorrhage Control – Direct Pressure	X
70	Hemorrhage Control - Dressing	X
71	Hemorrhage Control – Tourniquet	X
IMMOBILIZATION		
73	Cervical Stabilization – Cervical Collar	2,OM
74	Spinal Immobilization – Long Board	2,OM
75	Cervical Stabilization – Manual	X
76	Spinal Immobilization – Seated Patient (KED, etc.)	2,OM
77	Extremity Stabilization - Manual	X
78	Extremity Splinting	2,OM
TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
79	Auto-Injector	X
80	Intramuscular (IM)	2,OM
MISCELLANEOUS		
82	Assisted Childbirth Delivery - Normal	X
83	Blood Pressure – Manual	X
84	Emergency Moves for Endangered Patients	X
85	Eye Irrigation	X
86	Taser Barb Removal	OM
MEDICATION FORMULARY		
88	Epinephrine (Adrenalin)	2,4,OM
89	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer	X
91	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	4X
93	Oxygen	X
94	Vaccinations - at the request of the public health district if credentialed in IM administration	5,OM
Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards		
OM=Optional Module		
Levels of Medical Supervision		
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau		2
Requires EMSPC protocol		4
Just In Time Training		5

Added: Vaccinations, line 94

EMTB94

AIRWAY / VENTILATION / OXYGENATION		
95	Airway – Nasal	X
96	Airway – Oral	X
97	Bag-Valve-Mask (BVM)	X
98	Cricoid Pressure (Sellick)	X
99	Demand Valve – Manually triggered, flow restricted, ventilation	X
100	Finger Sweep	X
101	Head-tilt/chin-lift	X
102	Jaw-thrust	X
103	Jaw-thrust - Modified (trauma)	X
104	Modified Chin Lift	X
105	Mouth-to-Barrier	X
106	Mouth-to-Mask	X
107	Mouth-to-Mouth	X
108	Mouth-to-Nose	X
109	Mouth-to-Stoma	X
110	Obstruction – Manual	X
111	Oxygen Therapy – Humidifiers	X
112	Oxygen Therapy – Nasal Cannula	X
113	Oxygen Therapy – Non-rebreather Mask	X
114	Oxygen Therapy – Partial Rebreather Mask	X
115	Oxygen Therapy – Simple Face Mask	X
116	Oxygen Therapy – Venturi Mask	X
117	Pulse Oximetry	2,OM
118	CO Oximetry	2,4,OM
119	Suctioning – Upper Airway	X
CARDIOVASCULAR / CIRCULATION		
120		
121	EKG - 12-lead data acquisition	2,OM
122	Cardiopulmonary Resuscitation (CPR)	X
123	Defibrillation – Automated / Semi-Automated	X
124	Hemorrhage Control – Direct Pressure	X
125	Hemorrhage Control - Dressing	X
126	Hemorrhage Control – Tourniquet	X
127	Impedance Threshold Device (ITD)	OM
128	Mechanical CPR Device	X
IMMOBILIZATION		
129		
130	Cervical Stabilization – Cervical Collar	X
131	Spinal Immobilization – Long Board	X
132	Cervical Stabilization – Manual	X
133	Spinal Immobilization – Seated Patient (KED, etc.)	X
134	Extremity Stabilization - Manual	X
135	Extremity Splinting	X
136	Extremity Splinting – Traction	X
137	MAST/PASG for Pelvic Immobilization Only	X
138	Pelvic Immobilization Devices	OM

TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
139	Auto-Injector	X
140	Buccal	X
141	Intramuscular (IM)	2,OM
142	Oral	X
143	Subcutaneous	2,OM
144	MISCELLANEOUS	
145	Assist with Prescribed Meds	X
146	Assisted Childbirth Delivery - Normal	X
147	Assisted Childbirth Delivery- Complicated	X
148	Blood Glucose Monitoring - Automated	2,4,OM
149	Blood Pressure – Manual	X
150	Blood Pressure – Automated	X
151	Emergency Moves for Endangered Patients	X
152	Eye Irrigation	X
153	Mechanical Patient Restraints	X
154	Rapid Extrication	X
155	Taser Barb Removal	OM
156	MEDICATION FORMULARY	
157	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	OM
158	Epinephrine (Adrenalin)	2,4,OM
159	Glucagon	2,4,OM
160	Glucose (Oral)	X
161	Inhaled Beta Agonist (MDI)	X**
162	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	5X
163	Nitroglycerin - Sublingual	X**
164	Oxygen	X
165	Vaccinations - at the request of the public health district if credentialed in IM administration	5,OM

Education based on Idaho Standard Curriculum (ISC) which was based on National Standard Curricula		
OM=Optional Module		
Levels of Medical Supervision		
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau		2
Requires EMSPC protocol		4
Just In Time Training		5
** May carry and administer only if already prescribed		

Added: Vaccinations, line 165

EMT-2011

AIRWAY / VENTILATION / OXYGENATION		
166	Advanced Airway devices not intended to be inserted into trachea	2,3,OM~
167	Airway – Nasal	X
168	Airway – Oral	X
169	Bag-Valve-Mask (BVM)	X
170	Cricoid Pressure (Sellick)	X
171	Demand Valve – Manually triggered, flow restricted, ventilation	X
172	End Tidal CO ₂ Monitoring/Capnometry	2,3,OM~
173	Finger Sweep	X
174	Head-tilt/chin-lift	X
175	Jaw-thrust	X
176	Jaw-thrust - Modified (trauma)	X
177	Modified Chin Lift	X
178	Mouth-to-Barrier	X
179	Mouth-to-Mask	X
180	Mouth-to-Mouth	X
181	Mouth-to-Nose	X
182	Mouth-to-Stoma	X
183	Obstruction – Manual	X
184	Oxygen Therapy – Humidifiers	X
185	Oxygen Therapy – Nasal Cannula	X
186	Oxygen Therapy – Non-rebreather Mask	X
187	Oxygen Therapy – Partial Rebreather Mask	X
188	Oxygen Therapy – Simple Face Mask	X
189	Oxygen Therapy – Venturi Mask	X
190	Pulse Oximetry	X
191	CO Oximetry	2,4,OM
192	Suctioning – Tracheobronchial via advanced airway	2,OM
193	Suctioning – Upper Airway	X
194	Ventilators – Automated Transport (ATV) for non-intubated patients	X
CARDIOVASCULAR / CIRCULATION		
196	EKG - 12-lead data acquisition	2,OM
197	Cardiopulmonary Resuscitation (CPR)	X
198	Defibrillation – Automated / Semi-Automated	X
199	Hemorrhage Control – Direct Pressure	X
200	Hemorrhage Control – Dressing	X
201	Hemorrhage Control – Tourniquet	X
202	Impedance Threshold Device (ITD)	OM
203	Mechanical CPR Device	X
IMMOBILIZATION		
205	Cervical Stabilization – Cervical Collar	X
206	Spinal Immobilization – Long Board	X
207	Cervical Stabilization – Manual	X
208	Spinal Immobilization – Seated Patient (KED, etc.)	X
209	Extremity Stabilization - Manual	X
210	Extremity Splinting	X
211	Extremity Splinting – Traction	X
212	MAST/PASG for Pelvic Immobilization Only	X
213	Pelvic Immobilization Devices	OM
VASCULAR ACCESS / FLUIDS		
215	Intraosseous – Pediatric	2,OM
216	Intraosseous – Adult	2,OM
217	Peripheral – Initiation (includes External Jugular)	2,OM
218	IV Fluid infusion - Non-medicated	2,OM

TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
219	Auto-Injector	X
220	Buccal	X
221	Intramuscular (IM)	2,OM
222	Intraosseous – Pediatric	2,4,OM
223	Intraosseous – Adult	2,4,OM
224	Oral	X
225	Subcutaneous	2,OM
MISCELLANEOUS		
227	Assist with Prescribed Meds	X
228	Assisted Childbirth Delivery - Normal	X
229	Assisted Childbirth Delivery- Complicated	X
230	Blood Glucose Monitoring - Automated	2,4,OM
231	Blood Pressure – Manual	X
232	Blood Pressure – Automated	X
233	Emergency Moves for Endangered Patients	X
234	Eye Irrigation	X
235	Mechanical Patient Restraints	X
236	Rapid Extrication	X
237	Taser Barb Removal	OM
238	Venous Blood Sampling – Obtaining	2,OM
MEDICATION FORMULARY		
240	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	X
241	Activated Charcoal	X
242	Epinephrine (Adrenalin)	X
243	Glucagon	2,4,OM
244	Glucose (Oral)	X
245	Inhaled Beta Agonist (MDI)	X**
246	Inhaled Beta Agonist (SVN)	X**
247	Lidocaine - as an adjunct for IO fluid administration	4,OM
248	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer	X
249	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote)	X
250	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	4X
251	Nitroglycerin - Sublingual	X**
252	Oxygen	X
253	Vaccinations - at the request of the public health district if credentialed in IM administration	5,OM

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires additional standards as defined by the EMSPC	3
Requires EMSPC protocol	4
Just In Time Training	5
~End Tidal CO2 Monitoring/ Capnometry must be included if the Supraglottic Airway is selected as an EMT-2011 2,3 OM	
* Adults Only	
** May carry and administer only if already prescribed	

Changed:

"Technique of Medication Administration" lines 222 & 223 from "2,OM" to "2,4,OM" for Intraosseous because Lidocaine as an adjunct is the only medication administered at this level

Added:

Lidocaine as an adjunct for IO fluid administration, line 247
Vaccinations, line 256

AEMT85

AIRWAY / VENTILATION / OXYGENATION		
257	Advanced Airway devices not intended to be inserted into trachea	X*
258	Airway – Nasal	X
259	Airway – Oral	X
260	Bag-Valve-Mask (BVM)	X
261	CPAP	2,OM
262	Cricoid Pressure (Sellick)	X
263	Demand Valve – Manually triggered, flow restricted, ventilation	X
264	End Tidal CO ₂ Monitoring/Capnometry	2,OM
265	Finger Sweep	X
266	Head-tilt/chin-lift	X
267	Jaw-thrust	X
268	Jaw-thrust - Modified (trauma)	X
269	Modified Chin Lift	X
270	Mouth-to-Barrier	X
271	Mouth-to-Mask	X
272	Mouth-to-Mouth	X
273	Mouth-to-Nose	X
274	Mouth-to-Stoma	X
275	Obstruction – Manual	X
276	Oxygen Therapy – Humidifiers	X
277	Oxygen Therapy – Nasal Cannula	X
278	Oxygen Therapy – Non-rebreather Mask	X
279	Oxygen Therapy – Partial Rebreather Mask	X
280	Oxygen Therapy – Simple Face Mask	X
281	Oxygen Therapy – Venturi Mask	X
282	Pulse Oximetry	2,OM
283	CO Oximetry	2,4,OM
284	Suctioning – Tracheobronchial via advanced airway	X
285	Suctioning – Upper Airway	X
CARDIOVASCULAR / CIRCULATION		
287	EKG - 12-lead data acquisition	2,OM
288	Cardiopulmonary Resuscitation (CPR)	X
289	Defibrillation – Automated / Semi-Automated	X
290	Hemorrhage Control – Direct Pressure	X
291	Hemorrhage Control – Dressing	X
292	Hemorrhage Control - Pressure Point	X
293	Hemorrhage Control – Tourniquet	X
294	Impedance Threshold Device (ITD)	OM
295	Mechanical CPR Device	X
IMMOBILIZATION		
297	Cervical Stabilization – Cervical Collar	X
298	Spinal Immobilization – Long Board	X
299	Cervical Stabilization – Manual	X
300	Spinal Immobilization – Seated Patient (KED, etc.)	X
301	Extremity Stabilization - Manual	X
302	Extremity Splinting	X
303	Extremity Splinting – Traction	X
304	MAST/PASG for Pelvic Immobilization Only	X
305	Pelvic Immobilization Devices	OM
VASCULAR ACCESS / FLUIDS		
307	Intraosseous – Pediatric	X
308	Intraosseous – Adult	OM
309	Peripheral – Initiation (includes External Jugular)	X
310	IV Fluid infusion - Non-medicated	X

AEMT85

TECHNIQUE OF MEDICATION ADMINISTRATION	
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.	
311 Auto-Injector	X
312 Buccal	X
313 Intramuscular (IM)	2,OM
314 Intraosseous - Pediatric	2,4,OM
315 Intraosseous - Adult	2,4,OM
316 Oral	X
317 Subcutaneous	2,OM
MISCELLANEOUS	
319 Assist with Prescribed Meds	X
320 Assisted Childbirth Delivery - Normal	X
321 Assisted Childbirth Delivery- Complicated	X
322 Blood Glucose Monitoring - Automated	X
323 Blood Pressure – Manual	X
324 Blood Pressure – Automated	X
325 Emergency Moves for Endangered Patients	X
326 Eye Irrigation	X
327 Mechanical Patient Restraints	X
328 Rapid Extrication	X
329 Taser Barb Removal	OM
330 Venous Blood Sampling – Obtaining	X
MEDICATION FORMULARY	
332 Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	OM
333 Activated Charcoal	X
334 Epinephrine (Adrenalin)	2,4,OM
335 Glucagon	2,4,OM
336 Glucose (Oral)	X
337 Inhaled Beta Agonist (MDI)	X**
338 Lidocaine - as an adjunct for IO fluid administration	4,OM
339 Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	5X
340 Nitroglycerin - Sublingual	X**
342 Oxygen	X
343 Vaccinations - at the request of the public health district if credentialed in IM administration	5,OM

Education based on Idaho Standard Curriculum (ISC) which was based on National Standard Curricula	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires EMSPC protocol	4
Just In Time Training	5
* Adults Only	
**may carry and administer only if already prescribed	

Changed:

"Technique of Medication Administration" lines 314 & 315 from "X and OM" to "2,4,OM" for Intraosseous because Lidocaine as an adjunct is the only medication administered at this level

Added:

Lidocaine as an adjunct for IO fluid administration, line 338
Vaccinations, line 343

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344	AIRWAY / VENTILATION / OXYGENATION	
345	Advanced Airway devices not intended to be inserted into trachea	X*
346	Airway – Nasal	X
347	Airway – Oral	X
348	Bag-Valve-Mask (BVM)	X
349	CPAP	2,OM
350	Cricoid Pressure (Sellick)	X
351	Demand Valve – Manually triggered, flow restricted, ventilation	X
352	End Tidal CO ₂ Monitoring/Capnometry	2,OM
353	Finger Sweep	X
354	Head-tilt/chin-lift	X
355	Jaw-thrust	X
356	Jaw-thrust - Modified (trauma)	X
357	Modified Chin Lift	X
358	Mouth-to-Barrier	X
359	Mouth-to-Mask	X
360	Mouth-to-Mouth	X
361	Mouth-to-Nose	X
362	Mouth-to-Stoma	X
363	Obstruction – Manual	X
364	Oxygen Therapy – Humidifiers	X
365	Oxygen Therapy – Nasal Cannula	X
366	Oxygen Therapy – Non-rebreather Mask	X
367	Oxygen Therapy – Partial Rebreather Mask	X
368	Oxygen Therapy – Simple Face Mask	X
369	Oxygen Therapy – Venturi Mask	X
370	Pulse Oximetry	X
371	CO Oximetry	2,4,OM
372	Suctioning – Tracheobronchial via advanced airway	X
373	Suctioning – Upper Airway	X
374	Ventilators – Automated Transport (ATV) for non-intubated patients	X
375	CARDIOVASCULAR / CIRCULATION	
376	EKG - 12-lead data acquisition	2,OM
377	Cardiopulmonary Resuscitation (CPR)	X
378	Defibrillation – Automated / Semi-Automated	X
379	Hemorrhage Control – Direct Pressure	X
380	Hemorrhage Control – Dressing	X
381	Hemorrhage Control - Pressure Point	X
382	Hemorrhage Control – Tourniquet	X
383	Impedance Threshold Device (ITD)	OM
384	Mechanical CPR Device	X
385	IMMOBILIZATION	
386	Cervical Stabilization – Cervical Collar	X
387	Spinal Immobilization – Long Board	X
388	Cervical Stabilization – Manual	X
389	Spinal Immobilization – Seated Patient (KED, etc.)	X
390	Extremity Stabilization - Manual	X
391	Extremity Splinting	X
392	Extremity Splinting – Traction	X
393	MAST/PASG for Pelvic Immobilization Only	X
394	Pelvic Immobilization Devices	OM
395	VASCULAR ACCESS / FLUIDS	
396	Intraosseous – Pediatric	X
397	Intraosseous – Adult	X
398	Peripheral – Initiation (includes External Jugular)	X
399	IV Fluid infusion - Non-medicated	X

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TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
400	Aerosolized (MDI)	X
401	Auto-Injector	X
402	Buccal	X
403	Inhaled - patient administered (nitrous oxide)	X
404	Intramuscular (IM)	X
405	Intranasal	X
406	Intraosseous - Pediatric	X
407	Intraosseous - Adult	X
408	IV Push-D50/concentrated dextrose solutions only / Naloxone (Narcan)	X
409	Nebulized (SVN)	X
410	Oral	X
411	Subcutaneous	X
412	Sub-lingual	X
413	Topical	OM
MISCELLANEOUS		
415	Assist with Prescribed Meds	X
416	Assisted Childbirth Delivery - Normal	X
417	Assisted Childbirth Delivery- Complicated	X
418	Blood Glucose Monitoring - Automated	X
419	Blood Pressure – Manual	X
420	Blood Pressure – Automated	X
421	Emergency Moves for Endangered Patients	X
422	Eye Irrigation	X
423	Mechanical Patient Restraints	X
424	Rapid Extrication	X
425	Taser Barb Removal	OM
426	Venous Blood Sampling – Obtaining	OM
MEDICATION FORMULARY		
428	Acetylsalicylic Acid (Aspirin) for suspected cardiac chest pain	X
429	Activated Charcoal	X
430	Dextrose 50%	X
431	Dextrose, concentrated solutions	X
432	Epinephrine (Adrenalin)	X
433	Glucagon	X
434	Glucose (Oral)	X
435	Inhaled Beta Agonist (MDI)	X
436	Inhaled Beta Agonist (SVN)	X
437	Lidocaine - as an adjunct for IO fluid administration	4,OM
438	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote) self & peer	X
439	Atropine sulfate & 2-Pralidoxime chloride auto-injector (e.g. MARK-I, DuoDote)	X
440	Atropine sulfate & 2-Pralidoxime chloride auto-injector (Chempack patient use - emergency stockpile release only)	4X
441	Naloxone (Narcan)	X
442	Nitroglycerin - Paste	OM
443	Nitroglycerin - Sublingual	X
444	Nitrous Oxide (Nitronox)	X
445	Oxygen	X
446	Vaccinations - at the request of the public health district if credentialed in IM administration	X
Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards		
OM=Optional Module		
Levels of Medical Supervision		
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau		2
Requires EMSPC protocol		4
* Adults Only		

Added:

Lidocaine as an adjunct for IO fluid administration, line 437

Vaccinations, line 446

Paramedic - EMT98

AIRWAY / VENTILATION / OXYGENATION			
	Skill	Paramedic/ EMTP98	CC Skills EMTP98
447	Advanced Airway devices not intended to be inserted into trachea	X	
448	Airway – Nasal	X	
449	Airway – Oral	X	
450	Airway – Obstruction - removal of foreign body by direct laryngoscopy	X	
451	Bag-Valve-Mask (BVM)	X	
452	BiPAP		2,OM
453	Chest Decompression – Needle	X	
454	Chest Tube Placement		2,OM
455	Chest Tube – Monitoring & Management	X	
456	CPAP	OM	
457	Cricoid Pressure (Sellick)	X	
458	Cricothyrotomy – Needle/Percutaneous	X	
459	Cricothyrotomy - Surgical	X	
460	Demand Valve – Manually triggered, flow restricted, ventilation	X	
461	End Tidal CO ₂ Monitoring/Capnometry	X	
462	Finger Sweep	X	
463	Gastric Decompression – NG Tube	X	
464	Gastric Decompression – OG Tube	X	
465	Head-tilt/chin-lift	X	
466	Intubation – Digital	X	
467	Intubation – Medication Assisted (non-paralytic)	X	
468	Intubation – Medication Assisted (paralytics) (RSI)	2,3,OM	
469	Intubation - Nasotracheal	X	
470	Intubation - Orotracheal	X	
471	Intubation – Retrograde		
472	Jaw-thrust	X	
473	Jaw-thrust - Modified (trauma)	X	
474	Modified Chin Lift	X	
475	Mouth-to-Barrier	X	
476	Mouth-to-Mask	X	
477	Mouth-to-Mouth	X	
478	Mouth-to-Nose	X	
479	Mouth-to-Stoma	X	
480	Obstruction – Direct Laryngoscopy	X	
481	Obstruction – Manual	X	
482	Oxygen Therapy – Humidifiers	X	
483	Oxygen Therapy – Nasal Cannula	X	
484	Oxygen Therapy – Non-rebreather Mask	X	
485	Oxygen Therapy – Partial Rebreather Mask	X	
486	Oxygen Therapy – Simple Face Mask	X	
487	Oxygen Therapy – Venturi Mask	X	
488	PEEP – Therapeutic (>6cm H ₂ O pressure)		2,OM
489	Pulse Oximetry	X	
490	CO Oximetry	OM	
491	Suctioning – Tracheobronchial via advanced airway	X	
492	Suctioning – Upper Airway	X	
493	Ventilators – Automated Transport (ATV) for non-intubated patients	X	
494	Ventilators – Automated Transport (ATV)	X	
495	Ventilators, Automated – Enhanced Assessment & Management		2,OM

Paramedic - EMTP98

CARDIOVASCULAR / CIRCULATION		
	Skill	<div>Paramedic/ EMTP98</div> <div>CC Skills EMTP98</div>
496	EKG - 12-lead data acquisition	X
497	EKG - 12-lead interpretation	X
498	EKG - 3-lead rhythm interpretation	X
499	Cardiopulmonary Resuscitation (CPR)	X
500	Cardioversion – Electrical	X
501	Carotid Massage	X
502	Defibrillation – Automated / Semi-Automated	X
503	Defibrillation – Manual	X
504	Hemorrhage Control – Direct Pressure	X
505	Hemorrhage Control – Dressing	X
506	Hemorrhage Control - Pressure Point	X
507	Hemorrhage Control – Tourniquet	X
508	Impedance Threshold Device (ITD)	OM
509	IABP monitoring & management	2,OM
510	Invasive Hemodynamic Monitoring	2,OM
511	Mechanical CPR Device	X
512	Pericardiocentesis	2,OM
513	Pacing - Transcutaneous	X
514	Pacing - Transvenous & Epicardial – monitoring & management	2,OM
515	Pacing - Permanent/ICD	X
516	IMMOBILIZATION	
517	Cervical Stabilization – Cervical Collar	X
518	Spinal Immobilization – Long Board	X
519	Cervical Stabilization – Manual	X
520	Spinal Immobilization – Seated Patient (KED, etc.)	X
521	Extremity Stabilization - Manual	X
522	Extremity Splinting	X
523	Extremity Splinting – Traction	X
524	MAST/PASG for Pelvic Immobilization Only	X
525	Pelvic Immobilization Devices	OM
526	VASCULAR ACCESS / FLUIDS	
527	Arterial Line – Monitoring & Access Only	2,OM
528	Central Line – Placement	X
529	Central Line – Monitor & Maintain Only	X
530	Intraosseous – Pediatric	X
531	Intraosseous – Adult	X
532	Peripheral – Initiation (includes External Jugular)	X
533	Umbilical - Initiation	X
534	IV Fluid infusion - Non-medicated	X

Paramedic - EMTP98

TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
Skill	Paramedic/ EMTP98	CC Skills EMTP98
535 Aerosolized (MDI)	X	
536 Auto-Injector	X	
537 Buccal	X	
538 Endotracheal Tube (ET)	X	
539 Intramuscular (IM)	X	
540 Intranasal	X	
541 Intraosseous - Pediatric	X	
542 Intraosseous - Adult	X	
543 IV Infusion	X	
544 IV Programmable Volume Infusion Device		2,OM
545 IV Push	X	
546 IV Push-D50/concentrated dextrose solutions only / Naloxone (Narcan)	X	
547 Accessing Implanted Central IV Port	X	
548 Nasogastric	X	
549 Nebulized (SVN)	X	
550 Oral	X	
551 Rectal	X	
552 Subcutaneous	X	
553 Sub-lingual	X	
554 Topical	X	
MISCELLANEOUS		
556 Arterial Blood Sampling, Radial Site - Obtaining		
557 Assist with Prescribed Meds	X	
558 Over-the-Counter Medications (OTC)	X	
559 Assisted Childbirth Delivery - Normal	X	
560 Assisted Childbirth Delivery- Complicated	X	
561 Blood Chemistry Analysis		2,OM
562 Blood Glucose Monitoring - Automated	X	
563 Blood Pressure – Manual	X	
564 Blood Pressure – Automated	X	
565 Emergency Moves for Endangered Patients	X	
566 Eye Irrigation	X	
567 Eye Irrigation – Morgan Lens	X	
568 Mechanical Patient Restraints	X	
569 Rapid Extrication	X	
570 ICP Monitoring		2,OM
571 Taser Barb Removal	OM	
572 Urinary Catheterization	X	
573 Venous Blood Sampling – Obtaining	X	

Paramedic - EMTP98

MEDICATION FORMULARY		
	Formulary	
	Paramedic/ EMTP98	CC Skills EMTP98
574	Medical Director Approved Medications	X
575	Maintenance of Blood Administration	2,OM
576	Blood Products Administration	2,OM
577	Plasma Volume Expander Administration	2,OM

Education based on Idaho Standard Curriculum (ISC) which was based on National Standard Curricula	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires additional standards as defined by the EMSPC	3

No changes

Paramedic-2011

AIRWAY / VENTILATION / OXYGENATION			
	Skill	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
578	Advanced Airway devices not intended to be inserted into trachea	X	
579	Airway – Nasal	X	
580	Airway – Oral	X	
581	Airway – Obstruction - removal of foreign body by direct laryngoscopy	X	
582	Bag-Valve-Mask (BVM)	X	
583	BiPAP	X	
584	Chest Decompression – Needle	X	
585	Chest Tube Placement		2,OM
586	Chest Tube – Monitoring & Management	X	
587	CPAP	X	
588	Cricoid Pressure (Sellick)	X	
589	Cricothyrotomy – Needle/Percutaneous	X	
590	Cricothyrotomy - Surgical		2,OM
591	Demand Valve – Manually triggered, flow restricted, ventilation	X	
592	End Tidal CO ₂ Monitoring/Capnometry	X	
593	Finger Sweep	X	
594	Gastric Decompression – NG Tube	X	
595	Gastric Decompression – OG Tube	X	
596	Head-tilt/chin-lift	X	
597	Intubation – Digital	X	
598	Intubation – Medication Assisted (non-paralytic)	X	
599	Intubation – Medication Assisted (paralytics) (RSI)	2,3,OM	
600	Intubation - Nasotracheal	X	
601	Intubation - Orotracheal	X	
602	Intubation – Retrograde		
603	Jaw-thrust	X	
604	Jaw-thrust - Modified (trauma)	X	
605	Modified Chin Lift	X	
606	Mouth-to-Barrier	X	
607	Mouth-to-Mask	X	
608	Mouth-to-Mouth	X	
609	Mouth-to-Nose	X	
610	Mouth-to-Stoma	X	
611	Obstruction – Direct Laryngoscopy	X	
612	Obstruction – Manual	X	
613	Oxygen Therapy – Humidifiers	X	
614	Oxygen Therapy – Nasal Cannula	X	
615	Oxygen Therapy – Non-rebreather Mask	X	
616	Oxygen Therapy – Partial Rebreather Mask	X	
617	Oxygen Therapy – Simple Face Mask	X	
618	Oxygen Therapy – Venturi Mask	X	
619	PEEP – Therapeutic (>6cm H ₂ O pressure)	X	
620	Pulse Oximetry	X	
621	CO Oximetry	OM	
622	Suctioning – Tracheobronchial via advanced airway	X	
623	Suctioning – Upper Airway	X	
624	Ventilators – Automated Transport (ATV) for non-intubated patients	X	
625	Ventilators – Automated Transport (ATV)	X	
626	Ventilators, Automated – Enhanced Assessment & Management		2,OM

Paramedic-2011

CARDIOVASCULAR / CIRCULATION		
	Skill	Paramedic-2011 (Licensed after 1-1-2013) CC Skills Paramedic 2011
627	EKG - 12-lead data acquisition	X
628	EKG - 12-lead interpretation	X
629	EKG - 3-lead rhythm interpretation	X
630	Cardiopulmonary Resuscitation (CPR)	X
631	Cardioversion – Electrical	X
632	Carotid Massage	X
633	Defibrillation – Automated / Semi-Automated	X
634	Defibrillation – Manual	X
635	Hemorrhage Control – Direct Pressure	X
636	Hemorrhage Control – Dressing	X
637	Hemorrhage Control - Pressure Point	X
638	Hemorrhage Control – Tourniquet	X
639	Impedance Threshold Device (ITD)	OM
640	IABP monitoring & management	2,OM
641	Invasive Hemodynamic Monitoring	2,OM
642	Mechanical CPR Device	X
643	Pericardiocentesis	2,OM
644	Pacing - Transcutaneous	X
645	Pacing - Transvenous & Epicardial – monitoring & management	2,OM
646	Pacing - Permanent/ICD	2,OM
647	IMMOBILIZATION	
648	Cervical Stabilization – Cervical Collar	X
649	Spinal Immobilization – Long Board	X
650	Cervical Stabilization – Manual	X
651	Spinal Immobilization – Seated Patient (KED, etc.)	X
652	Extremity Stabilization - Manual	X
653	Extremity Splinting	X
654	Extremity Splinting – Traction	X
655	MAST/PASG for Pelvic Immobilization Only	X
656	Pelvic Immobilization Devices	OM
657	VASCULAR ACCESS / FLUIDS	
658	Arterial Line – Monitoring & Access Only	2,OM
659	Central Line – Placement	2,OM
660	Central Line – Monitor & Maintain Only	X
661	Intraosseous – Pediatric	X
662	Intraosseous – Adult	X
663	Peripheral – Initiation (includes External Jugular)	X
664	Umbilical - Initiation	2,OM
665	IV Fluid infusion - Non-medicated	X
666	IV Fluid infusion - Maintenance of Medicated Fluids	X

Paramedic-2011

TECHNIQUE OF MEDICATION ADMINISTRATION		
Only includes techniques required to administer meds listed in the medication formulary. Does not include techniques for assisting a patient in administering his/her own medications.		
Skill	Paramedic-2011 (Licensed after 1-1-2013)	CC Skills Paramedic 2011
667 Aerosolized (MDI)	X	
668 Auto-Injector	X	
669 Buccal	X	
670 Endotracheal Tube (ET)	X	
671 Inhaled - patient administered (nitrous oxide)	X	
672 Intramuscular (IM)	X	
673 Intranasal	X	
674 Intraosseous - Pediatric	X	
675 Intraosseous - Adult	X	
676 IV Infusion	X	
677 IV Piggyback	X	
678 IV Programmable Volume Infusion Device		2,OM
679 IV Push	X	
680 IV Push-D50/concentrated dextrose solutions only / Naloxone (Narcan)	X	
681 Accessing Implanted Central IV Port	X	
682 Nasogastric	X	
683 Nebulized (SVN)	X	
684 Oral	X	
685 Rectal	X	
686 Subcutaneous	X	
687 Sub-lingual	X	
688 Topical	X	
MISCELLANEOUS		
690 Arterial Blood Sampling, Radial Site - Obtaining		
691 Assist with Prescribed Meds	X	
692 Over-the-Counter Medications (OTC)	X	
693 Assisted Childbirth Delivery - Normal	X	
694 Assisted Childbirth Delivery- Complicated	X	
695 Blood Chemistry Analysis	X	
696 Blood Glucose Monitoring - Automated	X	
697 Blood Pressure – Manual	X	
698 Blood Pressure – Automated	X	
699 Emergency Moves for Endangered Patients	X	
700 Eye Irrigation	X	
701 Eye Irrigation – Morgan Lens	X	
702 Mechanical Patient Restraints	X	
703 Rapid Extrication	X	
704 ICP Monitoring		2,OM
705 Taser Barb Removal	OM	
706 Urinary Catheterization		2,OM
707 Venous Blood Sampling – Obtaining	X	

Paramedic-2011

MEDICATION FORMULARY		
	Formulary	Paramedic-2011 (Licensed after 1-1-2013) CC Skills Paramedic 2011
708	Medical Director Approved Medications	X
709	Maintenance of Blood Administration	X
710	Blood Products Administration	2,OM
711	Plasma Volume Expander Administration	2,OM

Education based on new 2011 Idaho EMS Curricula (IEC) which is based on National Education Standards	
OM=Optional Module	
Levels of Medical Supervision	
Requires completion of training that meets or exceeds specified state-wide training content established by the EMS Bureau	2
Requires additional standards as defined by the EMSPC	3

No changes

Paramedic Non-RSI Statewide Intubation Standards		
Topic	Requirements	Available Options
Patient Selection		
Adult / Peds	Unconscious w/ineffective respiration	
	Cardiac arrest	
	Apnea or agonal respirations	
	Conscious with ineffective respirations (Nasal intubations only)	
Equipment		
Laryngoscope blades	adult & ped blade sizes	Macintosh
	2 different blade types	Miller
		other blade types permissible
Continuous Pulse Oximetry	before, during & after intubation	
Rescue device	must have at least one available	LMA
		Combitube
		King LT
		bougie/flexguide
Tube placement	must have at least one available	ETCO2, qualitative
		esophageal detector device (EDD)
Selection of tube size	based on patient age or size of 5th finger	
Suction device	per minimum EMS Bureau equipment list	
Bag Valve Mask	per minimum EMS Bureau equipment list	
Oxygen	per minimum EMS Bureau equipment list	
Intubation Attempts		
Preoxygenation	100% oxygen prior to any attempts	Bag Valve Mask
		Non-Rebreather Mask
Provider limited to 3 attempts	duration: each attempt should be no more than 30 seconds. If unsuccessful should oxygenate before subsequent attempts.	
Patient limited to 5 attempts	multiple attempts should not delay transport	
NAEMSP definition of attempt: insertion of laryngoscope blade into mouth or insertion of tube through nares		
Confirmation of Tube Placement		
Confirmation of Tube Placement	Utilize multiple methods	Breath sounds
		Epigastric sounds
		ETCO2
		EDD
		chest rise
		tube misting
		Patient response
PCR Documentation		
See 'EMSPC Intubation PCR Documentation List' for required data elements.		

Required Elements for Performance Assessment and Improvement		
Monitoring		
100% chart review		
Intubation success rate		
	agency	
	provider	
1st attempt success rate		
	agency	
	provider	
Rescue airway device utilization		
Complications (agency vs provider)		
	R mainstem (unrecognized)	
	esophageal intubation (unrecognized)	
	airway/dental trauma	
	hypoxia during intubation	
	bradycardia during intubation	
	inappropriate tube size	
	inappropriate tube depth	
Training		
1. Minimum annual demonstration of intubation proficiency		
2. Minimum annual review of intubation to include cognitive and psychomotor components with an emphasis on team coordination.		
Remediation		
Remediation at the discretion of the local EMS medical director		

EMSPC RSI Statewide Standards

Topic	Requirements	Available Options
Patient Selection		
Adult /Peds	Patient requires intubation; AND is not flaccid, or has intact protective airway reflexes. Not a difficult airway	
Equipment		
Laryngoscope blades	adult & ped blade sizes	Macintosh
	2 different blade types	Miller
		other blade types permissible
Medications	As per local EMS Medical Director	
Continuous Pulse Oximetry	before during and after intubation	
Rescue device	must have at least one available	LMA
		Combitube
		King LT
		other
Tube placement	must have at least one available	ETCO2, qualitative
		esophageal detector device (EDD)
Selection of tube size	based on patient age or size of 5th finger	
Suction device	per minimum EMS Bureau equipment list	
Bag Valve Mask	per minimum EMS Bureau equipment list	
Oxygen	per minimum EMS Bureau equipment list	
Intubation Attempts		
Preoxygenation	100% oxygen prior to any attempts	Bag Valve Mask
		Non-Rebreather Mask
Provider limited to 3 attempts	duration: each attempt should be no more than 30 seconds. If unsuccessful should oxygenate before subsequent attempts.	
Patient limited to 5 attempts	multiple attempts should not delay transport	
NAEMSP definition of attempt: insertion of laryngoscope blade into mouth		
Confirmation of Tube Placement		
Confirmation of Tube Placement	Utilize multiple methods	Breath sounds
		Epigastric sounds
		ETCO2
		EDD
		chest rise
		tube misting
		Patient response
PCR Documentation		
See 'EMSPC Intubation PCR Documentation List' for required data elements.		

Required Elements for Performance Assessment and Improvement		
Monitoring		
100% chart review		
Intubation success rate		
	agency	
	provider	
1st attempt success rate		
	agency	
	provider	
Rescue airway device utilization		
Complications (agency vs provider)		
	R mainstem (unrecognized)	
	esophageal intubation (unrecognized)	
	airway/dental trauma	
	hypoxia during intubation	
	bradycardia during intubation	
	inappropriate tube size	
	inappropriate tube depth	
Training		
1. Minimum annual demonstration of intubation proficiency		
2. Minimum annual review of intubation to include cognitive and psychomotor components with an emphasis on team coordination.		
Remediation		
Remediation at the discretion of the local EMS medical director		

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, February 05, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Presentation:	Governor's Medicaid Redesign Workgroup Report and Recommendation	Richard Armstrong Director, Department of Health and Welfare Neva Santos, Executive Director Idaho Academy of Family Physicians

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 05, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson(Lodge), Nuxoll, Hagedorn, Tippetts, Lee and Lacey.

ABSENT/ EXCUSED: Senator Schmidt

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** convened the meeting at 3:01 p.m. He welcomed everyone there and turned the time over to Director Armstrong for his presentation.

PRESENTATION: **Richard Armstrong**, Director, Department of Health and Welfare (Department), began his presentation by introducing the other members of the work group who were attending with him: Senator Heider; Lisa Hrobsky, Hospital Association; Susie Pouliout, Idaho Medical Association; Corey Surber, St. Alphonsus Health System facilitator; Tom Fronk, Idaho Primary Care; Stephen Weeg, Governor's Health Care Council and board member of the Department of Health and Welfare; and Beth Gray, Nurse Practitioner Association. **Director Armstrong** indicated that the full report had been provided to the Committee. **Senator Heider** thanked them for their excellent work and participation in the Governor's work group.

Director Armstrong said that his presentation would cover five steps: 1) is the major initiative and how it will affect all of Idaho; 2) is Idahoan's access to healthcare. What that really means is the ability to pay equals access and how that is structured. 3) is the gap population, which is the group that the work group really focused on. These are individuals whose incomes are at 100 percent or less of the federal poverty guideline. 4) recommendations; and 5) strategies will be discussed last. There are three major healthcare initiatives. They are 1) State Healthcare Innovation Plan (SHIP), which is a strategy to change the delivery of healthcare throughout Idaho, 2) Traditional Medicaid reform, 3) Plugging the gap in healthcare coverage.

Neva Santos, Executive Director, Idaho Academy of Family Physicians (Academy), standing in for Dr. Epperly, stated that the Idaho Academy of Family Physicians has been involved with Idaho's healthcare discussions for many years. The Academy has been very involved in helping draft SHIP. The impact SHIP will have on Idahoans encompasses all of Idaho. SHIP envisions a healthcare system that is focused on keeping people healthy while reducing healthcare costs. The foundation of SHIP is the patient centered medical home (PCMH). This is the model of primary care that focuses on patients receiving the care that they need when they need it. A coordinated care model allows the patient to receive appropriate care without duplication of services and without overlooking an important medical issue. SHIP is designed to replace the fee for service payment system. This system tries to keep the patient healthy and rewards providers for working toward the same goal. Working as a team is much more efficient. Treatments are focused on wellness and preventative care. The SHIP plan will help transform 165 practices over 4 years to the PCMH model. Practices will become part of a PCMH neighborhood and will work with other healthcare providers in their communities. Regional health districts

have the best geographic alignment for the seven regional collaboratives. The entire system will be directed by the Idaho Healthcare Coalition.

Director Armstrong discussed the major similarities and differences between the PCMD and direct primary care (DPC). PCMHs is a patient centered approach to care with expanded services and access to providers. Providers are more focused on keeping patients well. The DPC model is also patient centered, focusing on keeping patients healthy and managing their chronic conditions, but differs in the reimbursement methodology. In both models the healthcare providers work to manage patients through care management options. In a DPC practice the providers have a direct contract with the patients and are able to bypass insurance. The patient is able to access the provider when they need care. The provider doesn't bill an insurance company because the care management fee is paid by the patient. SHIP is designed to transform Idaho's healthcare system by improving patient care, improving patient health outcomes and reducing healthcare costs.

Chairman Heider asked what Ms. Santos meant by wraparound insurance. **Ms. Santos** responded that the patient has a contract with the provider and they can contact their physician at any time. Then they pay for much less expensive wraparound insurance so that if they have to be hospitalized or go to an emergency room, they will be covered. **Senator Lacey** added that when you pay your provider it is like having a first insurance and the "wrap around insurance" would be a second insurance. His concern was who would pay for which services. **Ms. Santos** explained that the contract identifies what each company would pay for so there wouldn't be disagreements about which company pays for what.

Chairman Heider turned the time back to Director Armstrong. He indicated that he would discuss the traditional Medicaid reform which began in 2007. H 260 provided direction to the Department as well as authority to move into care management. It is under that umbrella that Medicaid reform is working. They are using the model of PCMHs to accomplish this. Their goal is to transition all Medicaid participants to the care management model. **Director Armstrong** said he would discuss where people get their insurance today. He specifically referenced the gap population, that included 78,000 individuals which represent 5 percent of the State's population. These people all have a household income of less than 100 percent of the federal poverty guideline. He indicated that services have been delivered to them through catastrophic funds and state indigent funds. The Department has had to deny coverage to many of these people because their income is too low to meet the subsidy standards. Adults without children are not included in Medicaid making them part of the gap population. The Department is a DCP for behavioral and mental health services. Clinicians deliver services directly to these people. They are the last resort for people who cannot receive help anywhere else. About 26 percent of all of the people coming through the program suffer from mental illness and other chronic diseases such as cancer, diabetes, or heart disease. Demographics of the gap population include households that have children; 68 percent have at least one full-time worker. The industries that they typically work in tend to be lower income jobs. They are able to track where these individuals live because of the registration with the State Insurance Exchange. The recommendation for helping to minimize this problem is to use a uniquely designed, hybrid model of healthcare consisting of care management for those under the 100 percent level and private market solutions or the insurance exchange for those above the 100 percent mark. It would have premiums and co-pays depending on their coverage. Attention would be paid to those that are medically fragile and they would be placed in proper coverage. Over 10 years, the savings would amount to over \$173 million, freeing up that money for other uses.

The care management group would be made up of those that are under 100 percent of the federal poverty guideline. They would be assigned to a primary care physician, shifting from fee-for-service to a value payment. Incentives would be offered to both participants and providers to work together. They would receive incentive credits toward a health reimbursement account which could be used for future co-pays and expenses. Healthy behavior would be rewarded. The plan would take advantage of all of the co-pays that are allowed by law. Medicaid is restricted by federal rule and the co-pays are small, but it is still a meaningful amount of money to this group. This would give them an incentive to take care of their health.

A discussion was then held on the group made up of those between 100-138 percent. That bracket is an overlap category that resulted from the new law and where Medicaid eligibility already was. It is estimated that there are about 25,000 individuals in this category. Similar plans that are in the exchange now would be used for this group. There would be premiums charged on a sliding scale. Participants would also be given job training and work search requirements. Another recent development is the ability to keep children with the private plan and not require them to split on to Medicaid separately. This results in one household being on two different types of insurance.

The funding side of the formula was then discussed. The federal government allows for an enhanced funding rate for the gap population. It started at 100 percent and goes down to 90 percent. Typically, the cost sharing is 70/30 for the remaining populations. There has been concern expressed that the federal government will not let people out of a program once they enter it. The program being used currently contains a trigger clause to opt out if an unfavorable change in federal funds occurs. A discussion was held concerning the benefits to taxpayers from participating in Healthy Idaho. The savings to Idaho grow as Idaho's population grows, and the expenditures would basically be transferred from counties and states to the federal government. A detailed report was given on what projected ten year savings/costs would be. The 10year total projection for total local savings was \$173.4 million. It is estimated that the federal dollars coming in in 2016 would be \$600 million. Idaho should continue to reap great savings in health care for this group of individuals.

The Affordable Care Act imposed a lot of taxes around healthcare. It was designed to have the taxes offset the costs. These taxes are being paid for by Idahoans. Idaho's share of the tax increase is estimated at \$25-\$50 million per year. Healthy Idaho feels it is only fair to make use of those dollars and get them back in Idaho.

The workgroup recommended taking two steps. They proposed considering draft legislation that changes eligibility to include the gap population, providing healthcare coverage through private and care management plans. Conversations with CMS indicate that they are receptive to this idea. It is a slightly different model, but none of what is being proposed is new. They are confident that they will approve such waivers and allow Idaho to amend their state plan.

Director Armstrong said that the Healthy Idaho Plan protects Idaho taxpayers. A three-year pilot program is being proposed. If it does not work or promised federal funding is not delivered, Idaho can opt out at any time. That wouldn't be easy. Those 78,000 people with that coverage would not be happy to lose it, but there is no other way to afford to help fund a health plan for the medically needy. This appears to be the best way to get health coverage for these individuals with the least impact to Idaho taxpayers (see attachment 1).

Director Armstrong asked for questions. **Chairman Heider** thanked him for all of his hard work for the people of Idaho.

Vice Chairman Martin asked if **Director Armstrong** knew approximately what the amount the co-pays would be. **Director Armstrong** indicated that Medicaid limits the amount of co-pays to small amounts such as \$4.00 or \$8.00. Providers struggle to bill these small co-pays. His division would be imposing those co-pays and using health reimbursement accounts to get people to realize that there is a cause and effect to use their services.

Senator Nuxoll asked if Medicaid expansion was being paid for with Medicare money, then aren't the plans just switching around from one group to another? **Director Anderson** stated that is part of the basic plan; it is a reallocation. Medicare is not needs driven, it is for everyone. Everyone pays the same price and the same premium. He stated that he didn't know why they decided to do reallocation and have it not affect the program.

Senator Hagedorn asked what the current start date was and the phase in plan to get all 78,000 people covered. **Director Anderson** said it would take a large portion of the year to phase out the old program. The start date would begin on the law start date. He estimated at least a year and that is if everyone moves quickly. **Senator Hagedorn** questioned the reality of saving \$64.7 million over the 10 year plan. **Director Armstrong** responded that this was a chance that could be achieved if they get started early. A lot of that depends on how quickly enrollment could be accomplished. **Senator Hagedorn** asked if the transition plan for an opt-out was discussed, how that would happen, and who would be responsible for putting it together. **Director Armstrong** indicated that he would be responsible. The enhanced funding is in the law so it would require Congress to go into the law and pull that percentage back. That would be a very obvious act that would cause a lot of problems. The GOP discussion is leaning toward a block grant and it works very well. If that actually happened, there would be rules for operation. If the dollars were fewer but options were given on how and where to spend the money, a way would be found through it. **Senator Hagedorn** expressed his concern with adding more people to an already over extended budget. **Director Armstrong** responded that Idaho depends on the federal government for approximately 70 percent of the money. He said he felt that the distribution of who pays more could help to pay for those who are not able to pay for themselves. This process would help by developing a structure for delivering the needed care and a better method of payment. He stated that if the federal government would give the states more latitude they would be able to protect the vulnerable for less money.

Senator Lacey asked if it would be possible to do legislation prior to having the federal government approve variances, or would approval be given for the variances before legislation is passed. **Director Armstrong** said that usually the legislation comes first, and then federal government approval is obtained. The federal government is hesitant to approve legislation before knowing if the State has approved it.

Senator Nuxoll said that she recognized that with Medicaid payments the doctors aren't getting paid as quickly as they should, there is a shortage of doctors, and Idaho's doctors are aging. She asked how that is going to work into this transition program. **Director Armstrong** said he agreed that Idaho is under served in the primary care physician category. As Idaho moves into the medical home model, they will be able to make greater use of the mid-level professionals. One of the current problems is that the physician has to take care of all of the things that mid-level professionals could do. This new pilot program should encourage development of the workforce in that area. **Senator Nuxoll** stated that she was concerned about what doctors would charge while working in this type of environment. **Director Armstrong** said that a pilot program was just completed, results showed that you can put chronic disease patients in a medical home where they get the attention they need, and by taking care of those needs, it reduced inpatient and emergency

room use. If those savings were invested into the system, it would increase the number of providers available and increase the capacity of primary care.

Senator Nuxoll asked if they were looking at health reform as a way to get out of Medicaid. **Director Armstrong** responded that the reason people need these services is because their income is too low. Household income has declined coming out of the recession. Once a household's income gets to the level where they can sustain themselves, they won't need these types of programs. They do job training and outreach programs to help these people get better paying jobs. As a result, they saw a decline in single people using their services because they were getting jobs, and they no longer needed these services. The family household still struggles.

Chairman Heider asked if the Committee was going to see draft legislation and who was going to draft it. **Director Armstrong** responded that there are people working on it, but he can't give details.

Chairman Heider thanked Director Anderson for his work and for his presentation.

ADJOURNED: **Chairman Heider** adjourned the meeting at 4:09 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Asst. Secretary

Healthy Idaho

An Idaho Alternative to Medicaid Expansion

February 5, 2015

Medicaid Redesign Workgroup



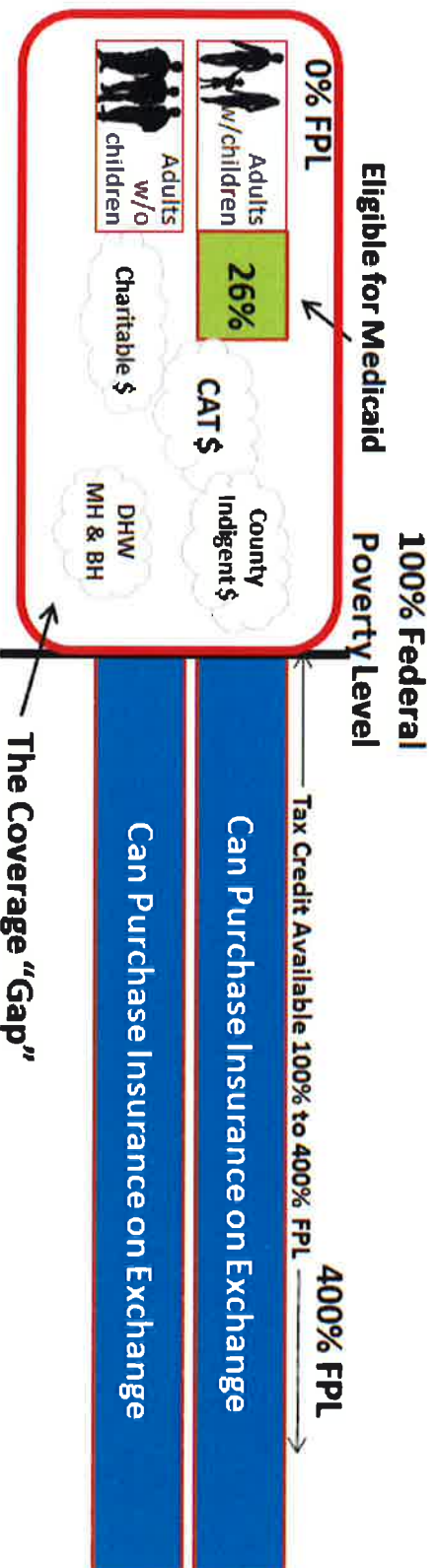
Today's Presentation

- 1. Aligning Idaho's healthcare initiatives**
- 2. Idahoans' access to healthcare**
- 3. The "Gap" population**
- 4. Workgroup recommendation**
- 5. Strategies / Next steps**



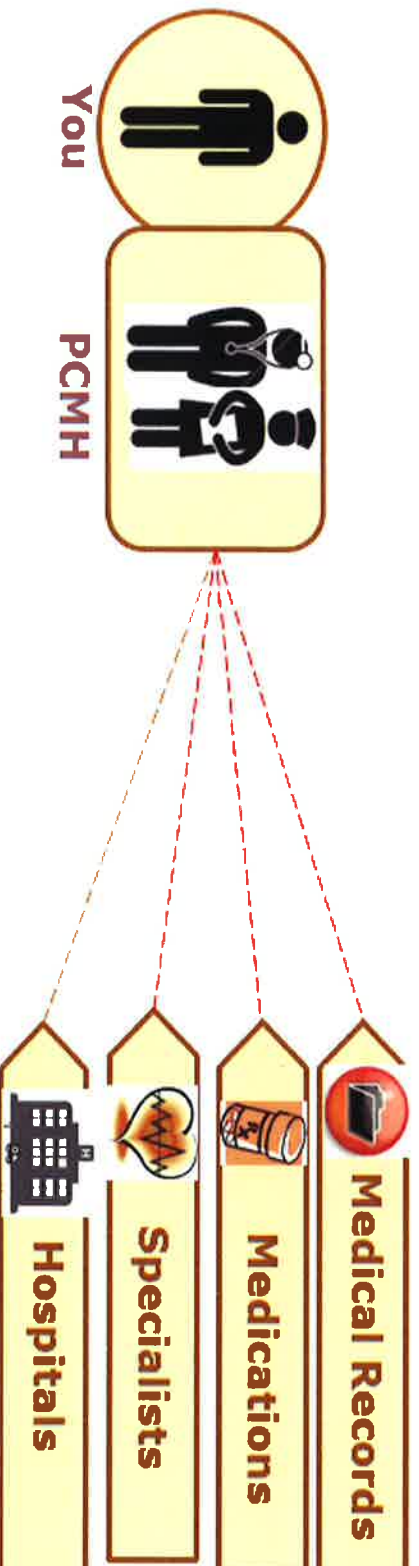
Idaho's Healthcare Initiatives

1. State Healthcare Innovation Plan (SHIP)
2. Traditional Medicaid reform
3. Plugging the "Gap" in healthcare coverage



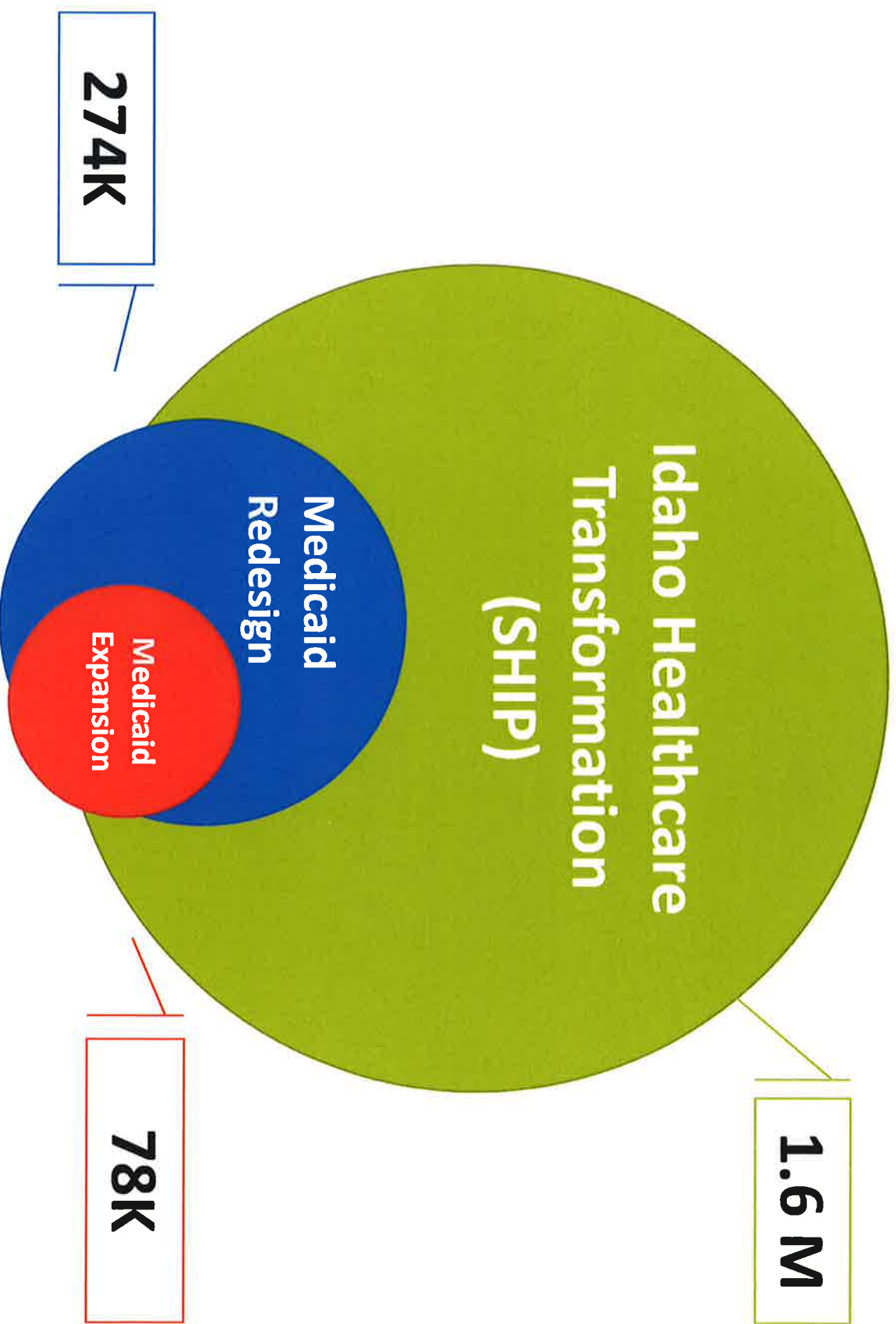
#1: State Healthcare Innovation Plan (SHIP)

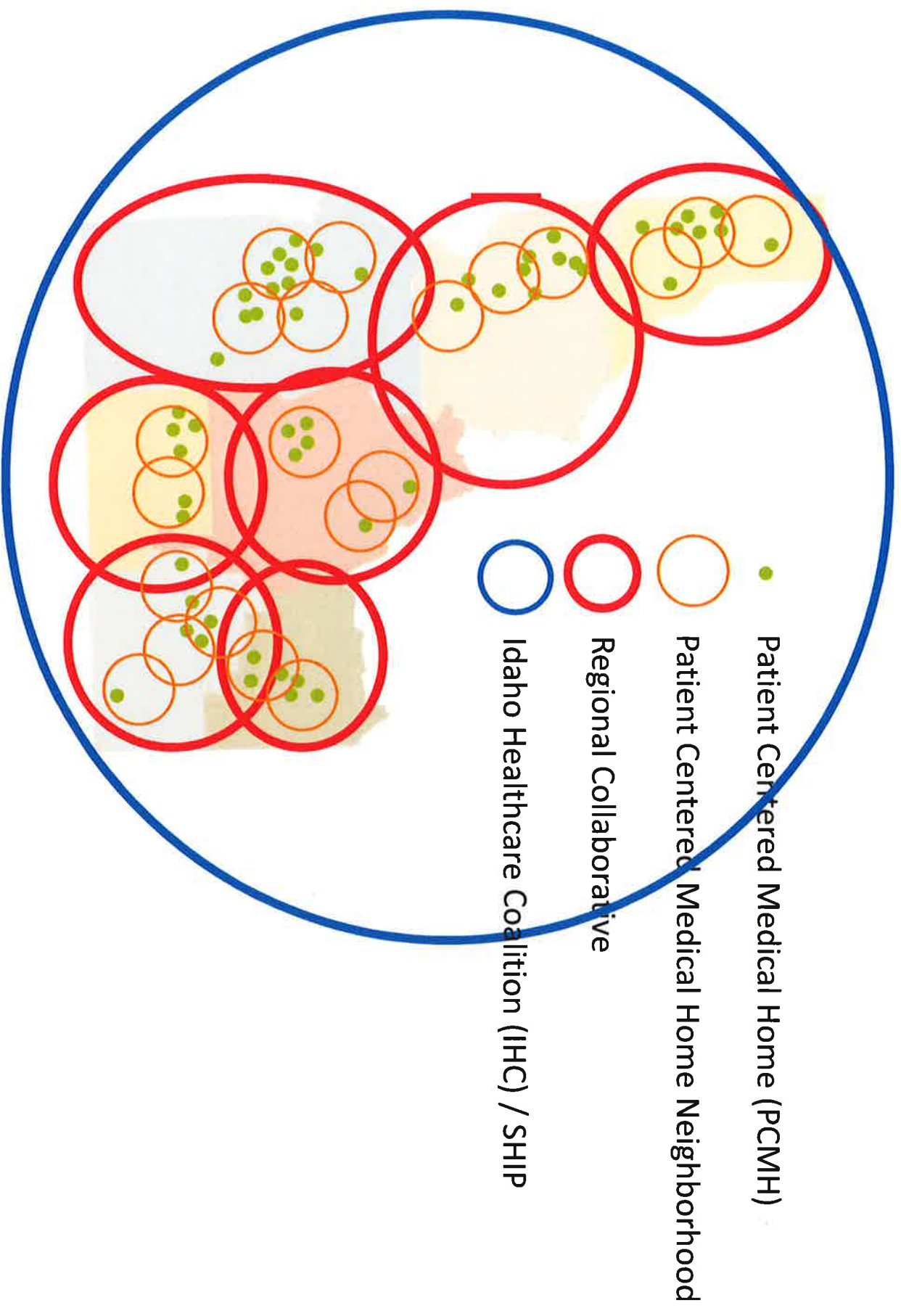
- Transform delivery system to patient-centered medical home model



- Multi-payer model, replacing fee-for-service with value-based reimbursement
- Incentives to both participant and provider for managing chronic conditions, wellness exams and preventive care
- PCMH and direct primary care are same model of care with differing reimbursement methodology

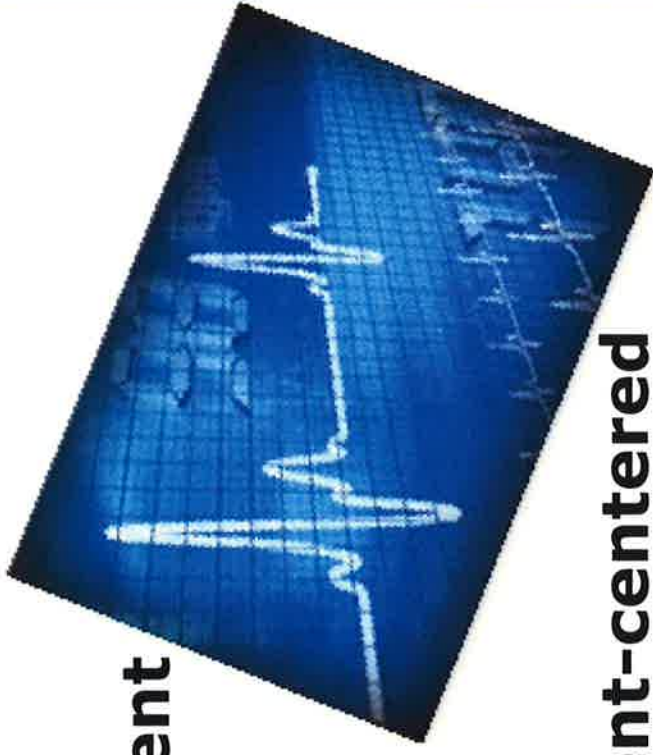
Three Synergistic Idaho Health Care Models





#2: Traditional Medicaid Reform

- Idaho Medicaid began moving to care management principles in 2007
- HB260 directed Idaho Medicaid to transition services to managed care
- Uses SHIP model of patient-centered medical homes to focus reimbursement on the value created through improved outcomes
- Goal: Transition all Medicaid participants to care management

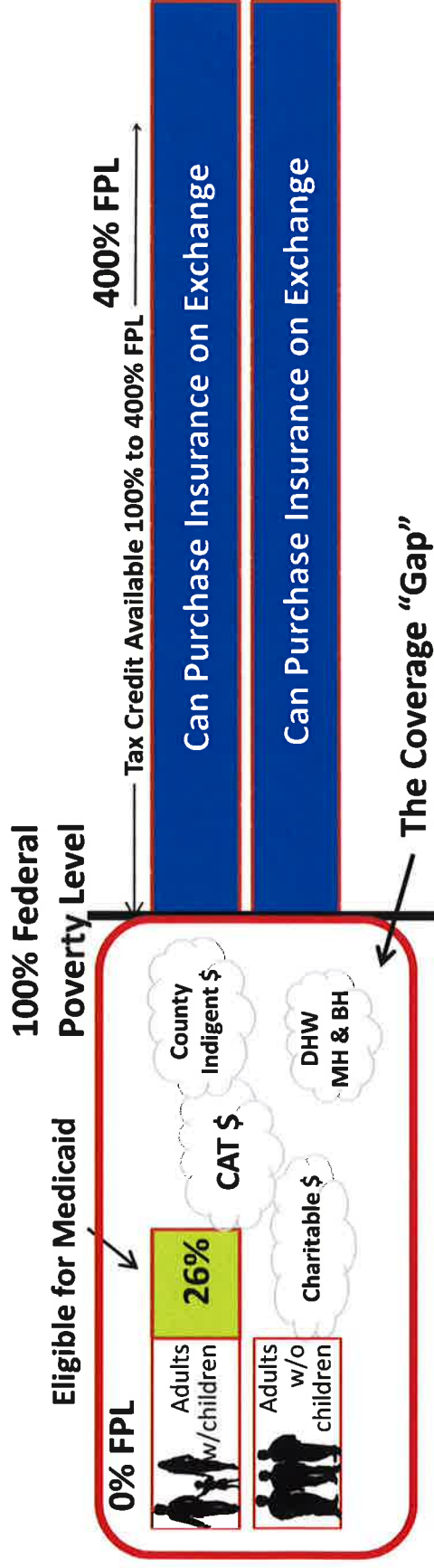


Idaho's Healthcare Coverage Landscape

Coverage Source	Enrollees	%
Employer	750,000	46%
Private/Exchange Eligible	264,000	17%
Medicaid	269,000	17%
Medicare	249,000	15%
Uninsured < 100% Poverty	78,000	5%
Total	1.61 Million	100%

- Workgroup focused on the 5% of Idahoans with no options
- Workgroup referred to this group as the "Gap" population because there is a gap in coverage between the extremely poor and higher income Idahoans.

The "Gap" Population: Adults 0-100% FPL



- Estimated at 78,000 adults
- Access crisis care through hospital emergency rooms, county indigent services, state CAT fund, or other charity care
- Uncompensated care costs are shifted to counties and state, along with higher insurance rates for employers and employees
- Charity care provides little continuity of care management
- Chronic diseases often progress to very expensive indigent costs

Gap Population: Demographics



78,000 Uninsured “Gap” Adults

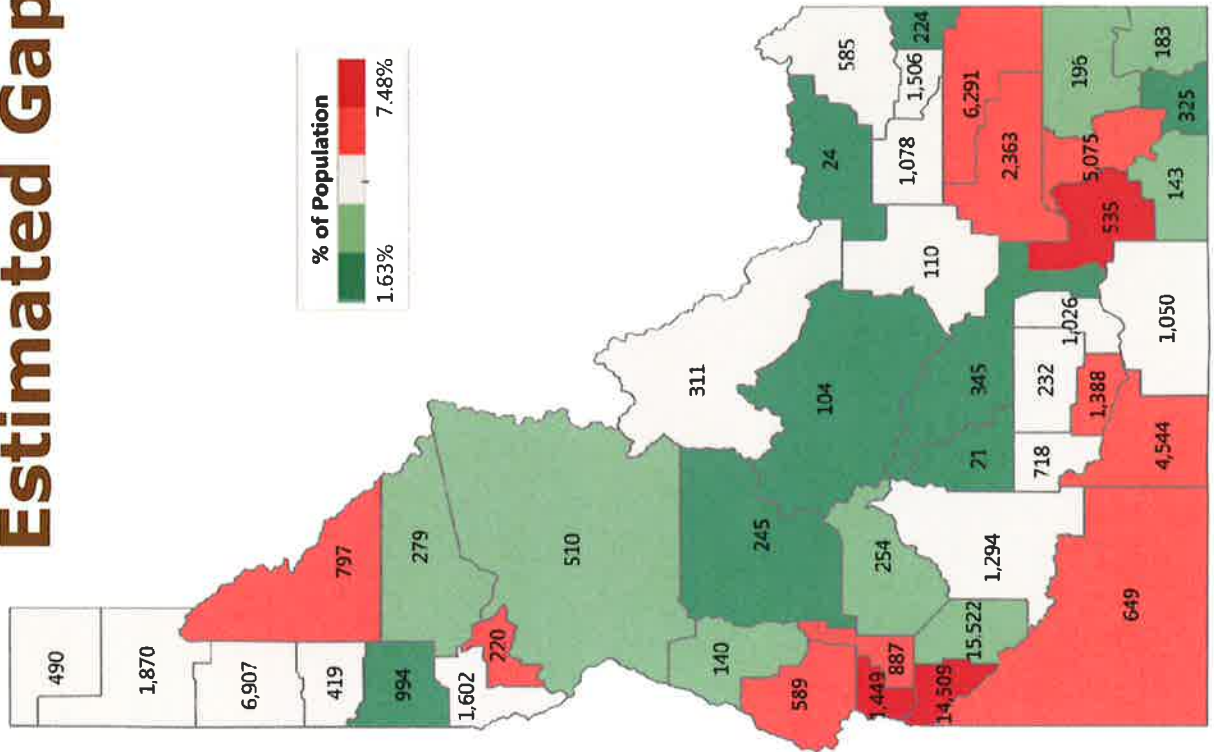
0 to 100% Federal Poverty Limit

Care Management

Who are the adults in the Gap?

- More than half have children in the home
- 68% of uninsured families have at least one full-time worker
 - Food service workers
 - Laborers in construction, farming and forestry
 - Home health aides, childcare workers, retail sales
 - Transportation, janitorial, office and administrative support

Estimated Gap Population by County



Recommendation: Healthy Idaho Plan

- Utilize a uniquely designed, hybrid model consisting of care management and private market solutions
- Charge premiums and collect maximum allowable copays from participants
- Medically fragile assessments
- Eliminate county/state indigent programs = Idaho taxpayer savings
- Save Idaho taxpayers >\$173 M. over 10 years, freeing money for education or other state priorities
- Bring home Affordable Care Act taxes Idahoans are paying, so they can be used for Idaho citizens
- Idaho can opt out at any time



February 5, 2015

Healthy Idaho: Care Management for Gap Adults



78,000 Uninsured "Gap" Adults

0 to 100% Federal Poverty Limit

Care Management

- Assign individuals to a primary care physician or direct primary care provider, adopting patient-centered medical home model to achieve better outcomes
- Shift the payment model from fee-for-service to value
- Offer incentives to both participants and providers to work together through health assessments, wellness exams, preventive screening and other healthy behaviors
- Utilize maximum allowable cost-sharing and require co-pays for non-emergent ER utilization
- Automatically refers participants to work search and job training

Healthy Idaho: Exchange Coverage 100-138%



78,000 Uninsured “Gap” Adults

0 to 100% Federal Poverty Limit



25,000 Adults

100% to 138% Poverty

Care Management/State Contract

Insurance
Exchange

- Supports a private market solution by purchasing insurance plans similar to the general public
- Higher cost sharing: Monthly premiums, deductibles and copays
- Refer all participants to job training/work search
- Children on Medicaid can join parents on private plan

Healthy Idaho: Federal/State Costs

Calendar Year	Federal Match Rate	State Share of Claims
2015-2016	100%	0%
2017	95%	5%
2018	94%	6%
2019	93%	7%
2021 and beyond	90%	10%

- Traditional Idaho Medicaid: Federal government pays 70% claims costs
- Healthy Idaho: Feds pay 90% to 100% claims costs
- During 50-year Medicaid history, states have consistently been paid promised federal share
- Healthy Idaho contains a trigger clause to opt out if an unfavorable change in federal funds occurs

Healthy Idaho: Taxpayer Savings

Savings	FY16	FY17	FY18	FY19
CAT Program (state)	\$35.6 M.	\$37.3 M.	\$39.1 M.	\$40.9 M.
Medical Indigent (county)	\$24.7 M.	\$25.7 M.	\$26.7 M.	\$27.8 M.
Medical Indigent (county admin.)	\$6.1 M.	\$6.3 M.	\$6.6 M.	\$6.8 M.
Behavioral Health (DHW)	\$9.7 M.	\$9.7 M.	\$9.7 M.	\$9.7 M.
Public Health (DHW)	\$800,000	\$800,000	\$800,000	\$800,000
Total Idaho Taxpayer Savings	\$76.8 M.	\$79.8 M.	\$82.9 M.	\$86 M.

Actuarial analysis conducted by Milliman consultants, November 2014

- **Healthy Idaho saves both county property taxes and state general funds**
- **County/state medical indigency programs are eliminated**
- **Savings can be used as tax break, or for education or other state/county priorities**

Healthy Idaho: 10 Year Savings / Costs

In Millions

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total
Total State Costs	\$12.1	\$29.2	\$51.5	\$60.9	\$78.6	\$93.8	\$97.6	\$101.7	\$106	\$110.6	\$742
Total Tax Savings	(\$76.8)	(\$79.8)	(\$82.9)	(\$86)	(\$89.3)	(\$92.7)	(\$96.3)	(\$100.1)	(\$104)	(\$107.8)	(\$915.4)
Net Costs	(\$64.7)	(\$50.5)	(\$31.2)	(\$25.1)	(\$10.7)	\$1	\$1.3	\$1.6	\$2.0	\$2.7	(\$173.4)

Actuarial analysis conducted by ~~Milliman~~ consultants, November 2014

- State costs include administrative and claims costs. 2016 is only administrative expenses; the feds pay 100% of claims' costs.
- Tax savings are state and county tax savings
- Net costs / (savings) are higher during earlier years when federal government pays higher share.
- 10-year projection for state and local savings of \$173.4 million.

Recovering ACA Taxes for Idahoans

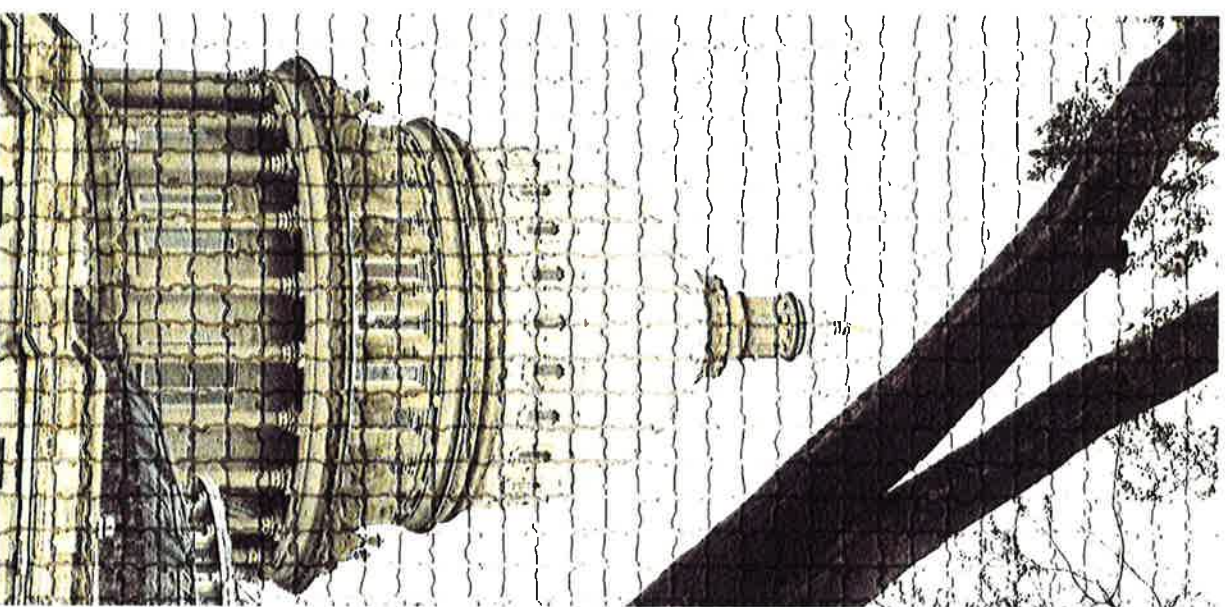
- New taxes were imposed by ACA
- Idaho's taxes are funding healthcare in other states
- Idaho's share of the tax increase is estimated at \$25-\$50 million per year*
- Healthy Idaho brings home ACA taxes that Idahoans are already paying



**Hawley Troxell, Attorneys at Law, estimated and calculated from IRS Data Book, 2013. Gross Collections by Type of Tax and by State.*

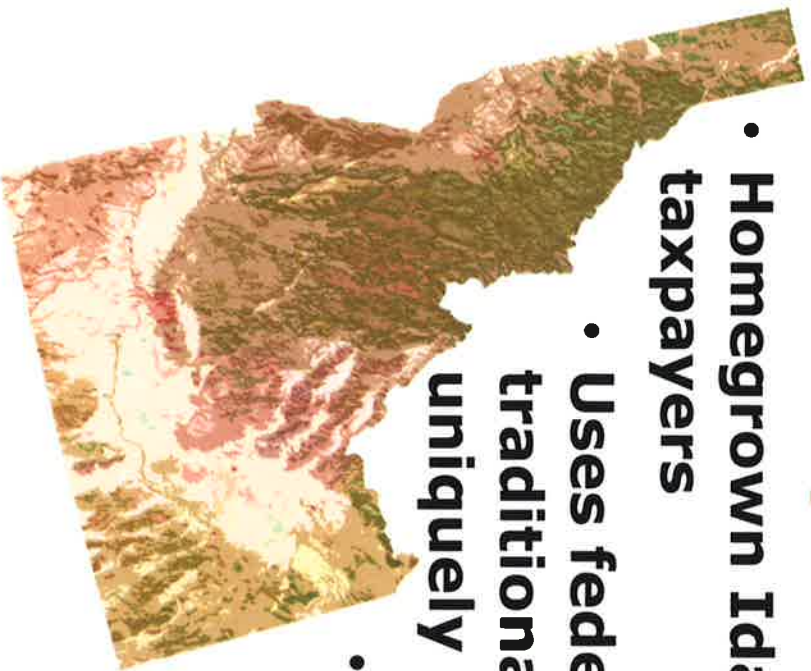
Next Steps

1. Consider draft legislation that changes eligibility to include the gap population, providing healthcare coverage through private and care management plans
2. Preliminary conversations with CMS indicate favorable consideration for the Healthy Idaho Plan; obtain federal waivers and amend state plan.



The Healthy Idaho Plan

- Homegrown Idaho solution that protects taxpayers
 - Uses federal funding targeted for traditional Medicaid expansion for a uniquely Idaho plan
 - Incorporates unprecedented concessions from the federal government to support Idaho values of personal responsibility and accountability
- Proposal is a three-year pilot. If program is not working or promised federal funding is not delivered, Idaho can opt out at any time



AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, February 09, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
<u>RS23485</u>	Relating to Psychologists - Amend to define a term, to grant specific rulemaking authority to the Board of Psychologist Examiners, and to Amend Chapter 23, Title 54 to add a new section	Kris Ellis Idaho Psychological Association
<u>S 1036</u>	RELATING TO DENTISTRY - Amending 54-923 - To Require Licensees to Provide Notice of Felony Convictions	Susan Miller Board of Dentistry
<u>S 1037</u>	RELATING TO DENTISTRY - Amending 54-920 - To Remove Language & Clarify License Status	Susan Miller Board of Dentistry
<u>S 1038</u>	RELATING TO PUBLIC ASSISTANCE - Amending 56-203B - To Prohibit Public Assistance Recipients from accepting direct payment of child support or forgiving unpaid support	Kandee Yearsley Bureau Chief Child Support Program Department of Health and Welfare

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 09, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson (Lodge), Nuxoll, Hagedorn, Tippetts, Lee and Schmidt

ABSENT/ EXCUSED: Senator Lacey

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:08 p.m. and welcomed Kris Ellis to the podium to present the first agenda item.

RS 23485 **Kris Ellis**, Eiguren Fisher Ellis, public policy group representing the Idaho Psychological Association (IPA), presented **RS 23485**, which is proposed to help solve the mental health care shortage in Idaho. The legislation would allow psychologists to have prescriptive authority, providing they adhere to stringent regulations. They must obtain their doctorate degree in psychology and a master's degree in psychopharmacology. They must also have clinical experience and pass a nationally recognized exam.

The proposed legislation also mandates that a prescribing psychologist must collaborate with the patient's primary care provider. The legislation also grants power to the Idaho Board of Psychological Examiners to establish an advisory panel. There is no impact on the General Fund.

Ms. Ellis asked the Committee to print **RS 23485** and stood for questions.

Senator Nuxoll asked why a psychologist would not want to become a psychiatrist. **Ms. Ellis** could not give a definitive answer but said there will be experts to answer that question when the bill is presented for a vote. **Senator Nuxoll** said she would like an answer to her question at that time.

Senator Tippetts declared a potential conflict of interest, because his son is employed with Eiguren Fisher and Ellis, which represents IPA.

Senator Johnson asked how many prescribing psychologists would be added to Idaho with the implementation of this amendment. **Ms. Ellis** said it may take a few years to realize the full benefit, but could potentially add 30 to 35 prescribing psychologists within 10 years.

MOTION: **Senator Hagedorn** moved to print **RS 23485**. **Senator Nuxoll** seconded the motion. The motion passed by **voice vote**.

S 1036 **Susan Miller**, Executive Director, Board of Dentistry (Board), presented **S 1036**, which provides grounds for revocation of a license for convictions of a crime. The proposed amendment would add a requirement that licensees must notify the Board of any felony conviction within 30 days of conviction. She said currently, there is no requirement for a licensee to report such information other than in their initial application or on a biennial renewal application. For that reason, the Board could potentially learn of a felony conviction months after an event.

Ms. Miller said in the interest of public safety, the Board feels the 30-day reporting requirement is reasonable. She said the amendment is supported by the Idaho State Dental Association and the Idaho Dental Hygienists Association. **Ms. Miller** asked the Committee to approve **S 1036** and stood for questions.

Questions raised by the Committee focused on when a licensee must report the felony (i.e., upon being charged or after conviction). **Ms. Miller** said the licensee must report the felony after the actual conviction. **Senator Nuxoll** asked if the rule applied to any felony or only those relating to the profession. **Ms. Miller** said the rule would apply to any felony.

MOTION: **Vice Chairman Martin** moved to send **S 1036** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

S 1037 **Ms. Miller** presented **S 1037**, which amends Idaho Code §§ 54-920 and 54-921 to clarify that failure to renew a license will result in the expiration of the license, and an expired license will be cancelled if not renewed within the 30-day grace period. The rule also establishes the requirement to reinstate a cancelled license if it is cancelled less than two years and provides the requirement to reinstate if the license is cancelled for longer than two years.

Ms. Miller reviewed the changes line-by-line. She explained the proposed amendment would provide for two categories under reinstatement: (1) licenses that have been cancelled for less than two years, and (2) licenses that have been cancelled for more than two years. **Ms. Miller** asked the Committee to approve **S 1037** and stood for questions.

MOTION: **Senator Schmidt** moved to send **S 1037** to the floor with a **do pass** recommendation. **Vice Chairman Martin** seconded the motion. The motion passed by **voice vote**. Vice Chairman Martin will carry both **S 1036** and **S 1037** on the floor.

S 1038 **Kandee Yearsley**, Child Support Bureau Chief, Department of Health and Welfare, Division of Welfare (Department), presented **S 1038**, relating to the collection of child support and reimbursement of public assistance.

The proposed change amends Idaho Code § 56-203B to specify that a benefit recipient does not have authority to forgive or receive direct payment of child support during the time they are receiving public assistance.

Ms. Yearsley said these requirements could help to reduce or eliminate reliance on future public assistance. She emphasized the amendment applies only to cases in which the family is currently receiving public assistance and the family is relying on taxpayer dollars to meet their needs because the court-ordered party is not paying their support.

Senator Tippetts expressed concern the language was not sufficiently explicit. **Ms. Yearsley** called on the Department's Deputy Attorney General for elaboration on the legal terminology.

Scott Keim, Deputy Attorney General, assigned to the Department's Child Support Program explained that while an individual is receiving public assistance, child support received is assigned to the State, and they would not have the ability to forgive that. He restated that the inability to forgive child support debt applies only during the time while the individual is on public assistance.

TESTIMONY: **Wayne Hoffman**, President of the Idaho Freedom Foundation, testified in opposition to **S 1038**. He expressed the opinion that the language is too restrictive and does not take into consideration the singular issues and needs unique to divorced parents.

TESTIMONY: **Bill Litster**, Boise, testifying as a private citizen, spoke in opposition to **S 1038**. He felt the restrictions would not allow divorced couples to work out their own particular difficulties and would be counter to helping the individuals move forward.

Senator Hagedorn expressed trepidation with the lines, "any attempt by a public assistance recipient to forgive or satisfy a support judgment shall have no legal effect." He felt the language could be a potential constitutional issue.

MOTION: **Senator Hagedorn** moved to hold **S 1038** in Committee. The motion was seconded by **Senator Nuxoll**.

SUBSTITUTE MOTION: **Senator Schmidt** moved to send **S 1038** to the 14th Order for amendment. **Senator Lacey** seconded the motion.

Vice Chairman Martin said he felt it would be better to hold **S 1038** until the Department can present reworded legislation that addresses the Committee's concerns.

Chairman Heider called for a roll call vote. **Vice Chairman Martin** and **Senators Johnson, Nuxoll, Hagedorn, and Tippetts** voted nay. **Senators Lee, Schmidt** and **Lacey** voted aye. The motion **failed**.

Chairman Heider called for a vote on the original motion. The motion carried by **voice vote**.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:33 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, February 10, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of Minutes for January 19, 2015 Approval of Minutes for January 21, 2015	Senator Lee Senator Lee
<u>S 1042</u>	RELATING TO HEALTH AND SAFETY - Amends existing law relating to residential care and assisted living facilities	Tamara Prisock Division Administrator Department of Health and Welfare
<u>S 1043</u>	RELATING TO HEALTH AND SAFETY - Amends existing law to provide that medical foster homes for veterans are exempt from certain requirements	Tamara Prisock Division Administrator Department of Health and Welfare

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 10, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson (Lodge), Hagedorn, Tippetts, Lee and Schmidt

ABSENT/ EXCUSED: Senators Nuxoll and Lacey

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m. and asked Senator Lee to lead approval of the Minutes.

MINUTE APPROVAL: **Senator Lee** moved to approve the Minutes of January 19, 2015. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

MINUTE APPROVAL: **Senator Lee** moved to approve the Minutes of January 21, 2015. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

Chairman Heider welcomed Tamara Priscock for the presentation of the next agenda items.

S 1042 **Tamara Priscock**, Administrator for the Division of Licensing and Certification, Department of Health and Welfare (Department), presented **S 1042**, which amends existing law related to residential care and assisted living facilities. **Ms. Priscock** explained the Division of Licensing and Certification worked with assisted living providers, advocates, and other stakeholders to streamline the licensing process, clarify requirements, and strengthen some of the requirements to better ensure residents' health and safety.

Ms. Priscock said changes in the lease of a property on which the facility is located do not affect the actual operation of the facility or the delivery of care to the residents. For this reason, changes in a lease should not require relicensure of the facility when ownership changes. She said removing the requirement for a facility to become relicensed when a lease is changed would save staff time and money for the facilities and save staff time for the Department.

Ms. Priscock asked the Committee to send **S 1042** to the floor with a do pass recommendation and stood for questions.

MOTION: **Vice Chairman Martin** moved that **S 1042** be sent to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

S 1043 **Ms. Priscock** presented **S 1043**, which would exempt homes approved by the Department of Veterans Affairs (VA) as medical foster homes from state certification for the care of dependent veterans who are not receiving Medicaid. She explained that a medical foster home is a private home approved by the VA where a caregiver provides long-term primary health care to veteran residents with serious chronic disease and disability. Homes approved by the VA as medical foster homes must meet requirements that are more strict than state requirements for a certified family home, and the homes are regularly inspected by the VA.

Ms. Priscock said for medical foster homes that care only for veterans who do not receive Medicaid, it is not logical to subject these homes to inspections by both the Department and the VA. She emphasized that homes caring for non-veterans, in addition to veterans receiving Medicaid, would still require state certification through the Department.

Ms. Priscock asked the Committee to send **S 1043** to the floor with a do pass recommendation and stood for questions.

Senator Tippetts asked if facilities would be receiving two inspections under this amendment where only one inspection is now required. **Ms. Priscock** explained that the Medical Foster Home Program is a new program being launched by the VA starting in the Treasure Valley and will expand around the State if the program is successful. She said as VA medical foster homes are recruited and established, the Department will continue to work closely with the VA to minimize duplication as much as possible.

MOTION: **Senator Hagedorn** moved to send **S 1043** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion. The motion passed by **voice vote**. Senator Hagedorn will carry **S 1042** and **S 1043** on the floor.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:18 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, February 11, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Presentation	Collaborative Workgroup on the Redesign of the Adult Developmental Disability Service System Presentation	Christine Pisani Executive Director Idaho Council on Developmentally Disabled

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 11, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson(Lodge), Nuxoll, Hagedorn, Tippetts, Lee and Schmidt.

ABSENT/ EXCUSED: Senator Lacey

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** convened the meeting at 3:00 p.m.

PRESENTATION: **Christine Pisani**, Executive Director, Idaho Council on Developmentally Disabled, shared with the Committee the vision, findings and 2015 initiatives of the Collaborative Work Group (CWG). The CWG is comprised of a range of people with developmental disabilities, service providers, advocates, agencies and policymakers. The CWG has set a goal to help developmentally disabled adults living in Idaho to enjoy the same opportunities, freedoms and rights as their neighbors by 2020. Developmentally disabled individuals have unique needs, and as such, the CWG seeks to design the system so it provides optimum support and opportunity for productive living (see attachment 1).

Chairman Heider asked the Committee if there were any questions. **Senator Hagedorn** said that developmental disability is typically defined as something that happened at birth. He asked if these services are applicable to people who have been in accidents and have had a traumatic brain injury. He wondered if they were part of the focus group. **Director Pisani** responded that federal and state guidelines state that if those injuries occur before the age of 21, then they typically do access services. For many people with such injuries the fit isn't always there with the current facilities available. **Senator Schmidt** asked if a discussion had been held on whether case management would be appropriate for such injuries. **Director Pisani** said that her organization supports a quality managed care model. There is no state that has incorporated people with developmental disabilities into a managed care model. It is possible that a managed care model would work, but more thought needs to go into that scenario. These services are typically ones that insurance companies don't think of supporting. Developmentally disabled people are not usually sick, they need services to support them in living their daily lives. She went on to state that as a result of H 260, their organization had been given the responsibility to work with the managed care model. **Senator Schmidt** said that he questions why managed care would not be an appropriate fit for these needs under the Medicaid system. **Director Pisani** explained that with approximately 28,000 people in Idaho living with a developmental disability, many do not qualify or don't access services for various reasons. The eligibility for the developmental disability waiver requires that an adult meet an institutional level of care, and that is determined based on the following criteria: A person must have an age equivalent score of 8 years old, and a general maladaptive score of -22 or below. There is an assessment process to go through to qualify for the developmental disability waiver. Most of the people living in the State either don't qualify or don't access the waiver services.

Vice Chairman Martin asked how many people out of the 28,000 who qualify for these services actually use them. **Director Pisani** said the number is estimated to be about 6,000 children and adults who are served through Medicaid. **Vice Chairman Martin** asked why the other 22,000 were not using the service. **Director Pisani** said that those are questions she doesn't have the answers to. She assumes that people are getting the support they need through their homes and communities or they do not qualify for the developmental disability waiver. **Senator Hagedorn** asked where the 28,000 number came from. **Director Pisani** responded that the number comes from a formula used to extrapolate numbers based on the population. It is an estimate that is used by all states.

Chairman Heider said that testimony would be given by Kelly Keelie.

TESTIMONY:

Mr. Keelie, a representative from Vocational Services of Idaho and a new member to the CWG, shared his excitement about being a part of this organization. He has been working with people with disabilities since 1978 in various capacities, and he feels very strongly that helping disabled people become employed is the most important thing that can be done. He sees the CWG accomplishing that goal.

Chairman Heider commented that he went to visit a young man who worked at Solo Cup and wondered if that would be part of this program. **Mr. Keelie** said that he assumed it was. There are all types of people working in different types of venues. A lot of individuals served by this organization receive a minimal amount of help through vocational rehab. With just the minimal support, they are able to hold jobs in the community. **Chairman Heider** suggested that the Legislators spend a day with some of the people in this program to get a firsthand experience.

Chairman Heider thanked everyone for attending the meeting. **Director Pisani** asked the Committee to read the report provided and thanked everyone for their time. **Senator Lee** pointed out the effort being made to be inclusive to all the individuals receiving these services is vital. **Director Pisani** stated that she is excited to be able to continue this work and to share Idaho's results with other states. **Vice Chairman Martin** said that he went to work with a young man at Marshalls. He commended this young man for working and also Marshalls for providing these types of work opportunities. **Director Pisani** stated that the "Take Your Legislator to Work Day" is an event to connect Legislators and work providers and to see the untapped work force that is available.

ADJOURNED: **Chairman Heider** adjourned the meeting at 3:30 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Asst. Secretary

Collaborative Work Group for Adults with Developmental Disabilities

February 11, 2015

ACCESS Idaho
Idaho Association of
Developmental Disability
Agencies
Case Management
Association of Idaho
Center on Disabilities and
Human Development
Division of Medicaid
Disability Rights Idaho
Idaho Council on
Developmental Disabilities
Vocational Rehabilitation
The Idaho Self-Advocate
Leadership Network
Residential Supported
Living Association
Division of Family and
Community Services
Vocational Services of Idaho
Idaho Health
Association/ICFs-ID
LINC/Centers for
Independent Living
Office of the Governor
Legislators

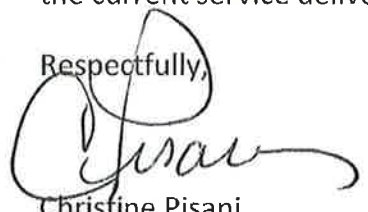
Senator Lee Heider, Chairman
Senate Health and Welfare Committee
Statehouse
Boise, ID 83720

Dear Chairman Heider and Committee Members:

Thank you for the opportunity to present the work of the Collaborative Workgroup on the Redesign of the Adult Developmental Disability service system. The report presented today represents a tremendous amount of work completed by many people over the past three years. The Collaborative Workgroup convened in 2011 and collectively we recognized the need to provide informed policy recommendations as a response to the directives from House Bill 260. Stakeholders also recognized we had an opportunity to create an improved service system. Each stakeholder holds this value and it has driven our commitment to the work.

I strongly encourage your review of our report. There is a significant amount of work included to help inform you of the current service delivery system, best practice in the field of developmental disabilities, research conducted, and the 2015 initiatives underway. All of the Collaborative Workgroup members are available to answer any questions or to be a resource to you to help understand the current service delivery system.

Respectfully,



Christine Pisani
Executive Director
Idaho Council on Developmental Disabilities

Executive Summary

2014 Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities: Findings and Initiatives January 27, 2015

Vision

The Collaborative Work Group (CWG) on Adult Developmental Disability (DD) Services represents a range of people with developmental disabilities, service providers, advocates, agencies and policymakers. This group has convened to constructively influence the development of Idaho's adult DD service system consistent with the following vision:

By 2020, adults with developmental disabilities living in Idaho enjoy the same opportunities, freedoms and rights as their neighbors. They have access to sustainable service systems that provide quality, individualized supports to meet their lifelong and changing needs, interests and choices.

Core Question

Given the unique and diverse needs of adults with developmental disabilities, the paid and unpaid, public and private nature of the system, and the finite resources available through Medicaid, the CWG seeks to design the system so it provides optimum supports and opportunity for productive living.

Findings

1. Idaho's self-direction option provides for a wide array of services, contingencies and choices
2. Employment is an important and desirable outcome for most people with DD
3. An opportunity exists to improve Idaho's assessment and resource allocation process
4. A managed care organization model is designed for medical care; it would be difficult to develop a managed care organization to appropriately serve the DD population

2015 Initiatives

1. Collaborate on Home and Community Based Services Rules Implementation
2. Revise the current assessment and resource allocation system to ensure that resources are matched to actual individual needs and aligned with the person centered planning process
3. Enroll Idaho as a participant in the National Core Indicators Project (<http://www.nationalcoreindicators.org>)
4. Generate a solid infrastructure, in coordination with University of Idaho's Center on Disabilities and Human Development, that provides the adult DD population an active, consistent and effective voice in systems change

2014 Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities: Findings and Initiatives

JANUARY 27, 2015



2014 Report of the Collaborative Work Group on Services for Adults with Developmental Disabilities” Findings and Initiatives

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APPENDIX B: STATE MATRIX
APPENDIX C: ARIZONA STUDY SUMMARY

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Introduction

Respect

The Collaborative Work Group (CWG) on Adult Developmental Disability (DD) Services is a group of individuals who have come together to constructively influence the development of Idaho's adult DD service system. Convened by the Idaho Council on Developmental Disabilities (ICDD) in November 2011, the group aspires to achieve the following vision:

By 2020, adults with developmental disabilities living in Idaho enjoy the same opportunities, freedoms and rights as their neighbors. They have access to sustainable service systems that provide quality, individualized supports to meet their lifelong and changing needs, interests and choices.

The CWG represents a range of people with developmental disabilities, service providers, advocates, state agencies and policymakers. It features an eight-member steering committee that meets monthly to do the detailed work. The steering committee presents its work to the full membership of the CWG for feedback and approval at least three times a year.

CWG seeks to influence the entire system, the core of which are Medicaid-paid services, as well as other important community and natural supports, paid and unpaid, such as employment, housing and transportation—supports essential to helping adults with developmental disabilities live meaningfully inclusive and productive lives.

CWG acknowledges and cautions that any changes to any part of the system recognize the impact of that change among other services, supports, systems and lives.

In its nearly 3 years of functioning, the CWG has undertaken the following scope of work, producing deliverables in most cases discussed in more detail later in this report. The CWG has

- Surveyed providers and people with disabilities to determine what is working and not working in the current system, generating a Checklist (See Attachment A) of qualities to feature in any proposed changes to the system
- Researched other states and compared respective assessment, service array and budgeting processes, detailed in a summary document (see Attachment B)
- Worked on and helped pass legislation for supported employment
- Visited and generated a corresponding report about the State of Arizona's system, where some CWG members met with state personnel, providers and adults with developmental disabilities to understand the nuances of that system in order to inform ideas about MCO functionality (see Attachment C)
- Generated a list of findings and features under development for the future system as presented in this document—the CWG's 2014 Report: Findings and Initiatives (Report)

- Initiated a more thorough examination and use of the existing Self Direction program to promote the opportunity and flexibility the existing program offers
- Initiated a study of needs assessment processes to ensure the best assignment of services and most appropriate allocation of financial resources

The findings and initiatives presented in this Report focus primarily on Idaho's Division of Medicaid (Medicaid) and support efforts undertaken by the Employment First Consortium. In addition to completing the more robust implementation of the Self Direction program and investigating effective and efficient improvements to the existing needs assessment process, in 2015 the CWG will look at the status, needs and opportunities related to the non-Medicaid aspects of the system—the community and natural supports so integral for living healthy and productive lives.

Always, the CWG work and recommendations are grounded in the following values:

- Respect
- Safety
- Choice
- Quality
- Community Inclusion

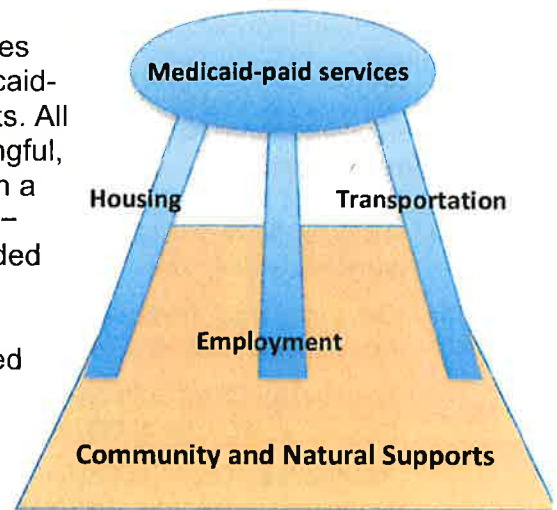
More information about the CWG, including an introductory video and group products, can be found on the ICDD website, at: <http://www.icdd.idaho.gov/projects/Adult%20Services/ASR.html>

Table 1: CWG Membership

CWG Members	Delegate	Alternate
ACCESS Idaho	Trinity Nicholson**	Lisa Cahill
Idaho Assoc. of Developmental Disability Agencies	Maureen Stokes**	Corey Makizuru
Case Management Assoc. of Idaho	Joanne Anderson	None
Care Providers Network of Idaho (CFHs)	Eva Blecha	Becky Solders
Center on Disabilities and Human Development, UI	Julie Fodor, PhD	Richelle Tierney**
Division of Medicaid	Art Evans**	Jean Christensen*
Disability Rights Idaho	Jim Baugh**	Dina Brewer
Council on Developmental Disabilities	Christine Pisani **	Tracy Warren
Vocational Rehabilitation	Jane Donnellan	None
Self Advocate Leadership Network	Noll Garcia*	Kristyn Herbert*
Residential Supported Living Assoc.	Bill Benkula **	None
Division of Family & Community Services (crisis)	Oscar Morgan	None
Vocational Services of Idaho	Kelly Keele**	Cassie Mills
Idaho Health Assoc./ICFs-ID	Tom Moss	Kris Ellis
LINC/Centers for Independent Living	Roger Howard	None
Office of the Governor	Tammy Perkins	None
Legislature	Rep. Sue Chew*	None
Legislature	Sen. Lee Heider	None

The Current Service System

The service system for adults with disabilities features an important combination of Medicaid-paid services and other community supports. All are required to enable adults to live meaningful, productive lives. Like a stool with its legs on a foundation—a range of community supports—Medicaid pays for many core services needed for eligible adults; however other non-Medicaid supports, such as housing, employment and transportation, are required to enable living as independently as possible. Without one key community support, other supports become more intensive and quality of life diminishes.



Developmental Disabilities – Idaho's Definition

The Section 66-402(5) Idaho Code defines a developmental disability as:

A chronic disability of a person that appears before 22 years of age and is

- Attributable to impairment such as mental retardation, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments.

The condition:

- Results in substantial functional limitations in three or more of the following areas of life activity: self-care, receptive and expressive language, learning, mobility self-direction, capacity for independent living, or economic self-sufficiency;
- Reflects the needs for a combination and sequence of special interdisciplinary or generic care, treatment or other services, which are of life-long or extended duration and individually planned and coordinated.

Services for Adults with Developmental Disabilities – An Overview

Medicaid Services

Medicaid is a federal program with a roughly 70/30 federal to state match providing funding for medical and health related services for people with low income in the United States. The Bureau of Developmental Disabilities Services (BDDS) within the Idaho Department of Health and Welfare Division of Medicaid manages the Medicaid-paid services for adults with developmental disabilities.

In Idaho, adults with developmental disabilities may be eligible for Medicaid benefits. Adults can apply for those benefits through an Idaho Department of Health and Welfare Independent Assessment Providers in a process that takes only a couple of hours. Eligibility is determined within a couple months.

The following services and supports are available for adults with developmental disabilities through Idaho Medicaid:

- Targeted Service Coordination—a service for individuals who cannot access, coordinate or maintain services on their own
- Developmental Therapy—skill development services provided through individual or group therapy in the home, community or a center
- Community Crisis Supports—interventions for individuals who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies
- Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) Services—an ICF/ID is a home for up to 8 individuals. The home has shared dining, living and cooking areas. Each individual can have a private bedroom or share a bedroom with another individual. Services provided by the ICF/ID are designed to meet the needs of individuals requiring in-home care, and provide services 24 hours a day

Through a Medicaid Waiver program (Medicaid Home and Community-Based Services §1915(c) of the Social Security Act), Medicaid provides each state the opportunity to provide an array of services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. States have broad discretion in designing the waiver program to best complement traditional Medicaid services, meet the needs of the state's population in a manner that is cost-effective, and employ a variety of service delivery approaches, including participant direction of services.¹ Medicaid Home and Community-Based Services Rules have been revised in 2014, providing even more flexibility, assurances and choice for the participant.

Idaho's Division of Medicaid has worked with intentionality to develop a quality waiver program, which features the following DD Waiver services:²

- Residential Habilitation—Certified Family Home and/or Supporting Living
 - Certified Family Home: an individual can live in the home of his/her parents, the home of another family member, or the home of someone in the community who is not related. Some supports and services will be provided in the home and some supports and services will be provided in the community.
 - Supporting Living Services: an individual can live in his/her own home, apartment, or an apartment with up to two other individuals. Supports and services can be provided in the home or apartment and in the community to help the individual live as independently as possible.
- Chore Services—might include washing windows, moving heavy furniture, or shoveling snow.

¹ <http://www.healthandwelfare.idaho.gov/Portals/0/Medical/DD%20Waiver.pdf>

² <http://www.healthandwelfare.idaho.gov/Portals/0/Medical/DevelopmentalDisabilities/Medicaid%20Services%20and%20Supports.pdf>

- Respite Services—services provided on a short-term basis due to the absence of the normal caregiver, and limited to the individual who lives with non-paid caregivers
- Supported Employment—provides support in a competitive work setting with job coaches who help the individual learn the job.
- Non-medical transportation—transportation to community services.
- Environmental Accessibility Adaptations—provides for certain interior and exterior changes to the home, which enable individuals who would otherwise be institutionalized to function with greater independence in the home.
- Specialized Medical Equipment and Supplies—additional supports when the state plan limits are used up, or the equipment or supply is not available under the regular state plan. Items must be necessary for the direct medical or remedial benefit of the individual.
- Personal Emergency Response Systems (PERS) A PERS unit is a portable or stationary device that is used to call for help in an emergency. This item is sometimes referred to as a “lifeline.”
- Home Delivered Meals—a service that delivers one or two nutritious meals each day for individuals who are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who are unable to prepare a meals without assistance.
- Skilled Nursing—Provides professional nursing services to individuals who need them. Nursing services must be recommended by a physician and must be listed on the participant’s plan.
- Behavioral Management and Crisis Management—This service is delivered to individuals who are having a psychological, behavioral or emotional crisis. Behavioral and crisis management is an emergency back up and provides direct support for the individual in crisis.
- Adult Day Health—a supervised and structured day program for individuals to receive a variety of social, recreational and health activities.
- Self-Directed Community supports—this is a Medicaid option for adults who are eligible for the DD waiver. This option provides participants the opportunity to make their own choices about supports, giving them freedom to manage their own lives. Participants do not have to choose supports alone. They have as much or as little help as they need from a support broker, a circle of support, and a fiscal employer agent (FEA).
 - Participants will have an individualized budget, create a support and spending plan, hire workers, and buy goods and services. Participants must agree to follow four guiding principles:
 - Freedom to plan their own lives
 - Control over their Medicaid dollars to buy supports and services
 - Support to become involved in their communities
 - Responsibility for their choices and decisions
 - If self-direction does not work, individuals can go back to receiving traditional Medicaid DD services.

Currently, approximately 3500 adults receive Medicaid waiver services in Idaho, served by approximately 100 Medicaid Providers. The services provided in Idaho are found to be more extensive than those provided in other states the CWG researched.

Community and Natural Supports

Any individual has a range of needs specific to their condition and community that must be met in order to live as independently and meaningfully as possible in their own community. CWG has identified the following list of essential needs:

- a. Food and Housing
- b. Health Care
- c. Safety
- d. Employment
- e. Development of Independent Living Skills
- f. Mental and Behavioral Health
- g. Integration in Community Activities
- h. Transportation
- i. Protection of Rights and Self Determination

Clearly, some of these needs can be met through Medicaid services but many of them cannot. Putting all these pieces together for a single individual in a specific location requires attentive planning and meaningful individual, family, agency, and community engagement.

The CWG defines community supports as those resources in the community needed by the individual to help them live their lives as fully as possible – those needs beyond what Medicaid can provide, but which may be paid or non-paid, provided by agencies and entities other than Health and Welfare (Housing, Vocational Education, Transportation, communities, families), and which complete the individual's system of care.

Work undertaken and anticipated by the CWG around community supports, specifically employment and housing, are discussed in more detail in future chapters of this report.

Core Question

Given finite resources available through Medicaid, and the unique and diverse needs of the adult DD population, the underlying question the CWG needs to address is how to design the system so it provides optimum supports and opportunity for productive living.

Research

Choice

To inform its understanding of DD system options and possibilities, the CWG studied the following 11 states:

- Arizona
- Colorado
- Florida
- Michigan
- New Mexico
- New York
- North Carolina
- Ohio
- Oregon
- Rhode Island
- Wyoming

Research involved reviewing the individual states' websites, and interviewing Directors, state Developmental Disabilities Councils, and state agency personnel.

Summarily, CWG learned many states authorize their services regionally instead of statewide, sometimes resulting in different rates and services in different regions of the state. Other states have long waiting lists. One common element was identified in many of the states CWG explored is using the Supports Intensity Scale (SIS) as the tool to establish budgets for adults with Intellectual and Developmental Disabilities. The National Office of United Cerebral Palsy has rated Arizona number one in the nation for service delivery for people who experience intellectual disabilities and developmental disabilities.

Arizona's system featured some components that warranted additional research, including functioning as a state-managed care organization (MCO), no wait lists, a responsive reimbursement methodology, and a heralded partnership between the state agencies, advocacy and provider groups.

In Arizona, state employees function as service coordinators and participate in individual Person-Centered-Planning³ meetings and plan development. The Arizona Department of Economic Security (equivalent to Idaho's Department of Health & Welfare) contracts with Raising Special Kids, the Arizona Parent Training Center, to conduct and oversee coordinator training. Extensive training is provided on a range of topics including education about how to develop unpaid supports, and how to help adults and families develop those supports where they may be limited or not currently in place.

One downfall in Arizona is that Arizona does not have a 1915(c) waiver – they operate an 1115 demonstration waiver. People who qualify for the 1115 must function on an individual cost neutrality. Individual cost neutrality means if they cannot pay for the supports they need for 24-hour care in their own home with

³ Person Centered Planning is an ongoing problem-solving process used to help people with disabilities plan for their future. In person centered planning, groups of people focus on an individual and that person's vision of what they would like to do in the future.

the funds they are provided, they must either have natural supports willing to sign a risk agreement with the state or they must live in a 6-8 bed group home. However, family members of children living in these group homes express satisfaction with the supports and services their loved ones receive.

Appendix B provides a summary of the states reviewed and description of how those systems work. Appendix C describes in more detail the findings of CWG study of Arizona's MCO-operated program, which had direct bearing on future considerations for Idaho's program presented in the next section.

Findings

Supports and services for people with developmental disabilities are most effective when they are flexible, adaptive and conform to the natural flow of the participant's needs, life and choices.

To provide appropriate supports for the DD community, a system of care must be broad and flexible, addressing an individual's needs for:

1. Food and Housing
2. Health Care
3. Safety
4. Employment
5. Development of Independent Living Skills
6. Mental and Behavioral Health
7. Integration in Community Activities
8. Transportation
9. Protection of Rights and Self Determination

Medicaid plays a leading role in providing health care, independent living skills and mental and behavioral health. Medicaid also has a role in providing for safety, employment, community integration, and transportation along with other state agencies and community supports. Food and housing are not part of the Medicaid program, except for people in long-term care facilities. People with developmental disabilities need help with obtaining and coordinating assistance from Medicaid and non-Medicaid service providers.

A good system of care will support as precisely as possible the approved services to meet an individual's unique needs, with reimbursement rates to match the actual cost of providing the service.

Findings

Federal Medicaid regulations can create challenges to flexibility and adaptability of services

Most Medicaid Services are specifically defined. Services are provided by people with specific qualifications employed by certified provider organizations. Services come in units, usually specific blocks of time. Each service has a specific reimbursement rate and billing code. These are features of a medical model of reimbursement for procedures and office visits. The CWG recognizes service definitions and rate setting create strong incentives and disincentives, and CWG seeks to be aware of the incentives it creates.

Life does not take place in defined time blocks. Life happens all of the time everywhere you go and whomever you are with. Life requires a kind of free flowing, constantly adapting, creative responsiveness. This is often incompatible with the discreet units of precisely defined billing codes, or "services".

Acknowledging this reality and addressing it to the extent possible in the design of the system is key to the CWG Vision for adults with developmental disabilities.

Idaho's self-direction option provides for a wide array of services, contingencies and choices

Idaho's "My Voice My Choice" (MVMC) self-directed (waiver) option makes possible a high level of participant choice, control and flexibility within the Medicaid system. It can be creatively adapted to a participant's needs and choices. It is possible to use the MVMC option to access services from traditional providers in a way that preserves choice and flexibility. This option currently serves 574 adults and has experienced steady growth.

In order to leverage those opportunities, CWG has, in partnership with the Division of Medicaid, embarked on an effort to generate a greater understanding of the opportunities the self-directed option affords by engaging participants and providers in the process of testing those opportunities, then measuring and reporting on outcomes in response. The CWG has undertaken a number of surveys to learn about levels of satisfaction with the self-directed option. Preliminary results indicate an opportunity to provide some education to dispel some of the myths and misinformation about who can access and how to access self-direction, as well as who may provide services within the option.

Employment is an important and desirable outcome for most people with DD

The Collaborative Work group endorses the efforts of Employment First Consortium, another group convened by the ICDD for the purpose of improving how employment services and systems work in Idaho so people with DD are able to reach their career goals. The Consortium provided specific employment service definitions and system improvement recommendations to inform the work of the CWG.

The CWG reviewed and supported legislation proposed by a collaborative workgroup including both CWG and Consortium members. The law was passed by the 2014 State Legislature and allows individuals to request additional service plan dollars for community supported employment services. One result of this statute change is that more people who are eligible for the DD waiver are able to include long-term employment support services under Medicaid in their service plan. This enables them to access vocational rehabilitation services rather than be added to the waitlist for the extended employment services program.

Employment provides individuals with developmental disabilities the opportunity to be an active participant in their community and to: build relationships, increase their social capital, improve their overall health, and become economically self-sufficient. Having a job has a positive effect on overall quality of life.

An opportunity exists to improve Idaho's assessment and resource allocation process

CWG purports assessments should:

- Provide information to establish eligibility for DD services and for waivers

- Determine the needs of participants and the amount and types of services that can meet those needs utilizing a person centered planning process
- Allocate resources consistent with the participant's needed support level

Idaho currently uses the Scales of Independent Behavior – Revised (SIB-R), which has not been updated or re-normed for a long time. There is some indication the SIB-R may be re-normed in the future, but there is no indication of when or whether it will be updated for use on current software systems.

There is also some dissatisfaction with how the SIB-R is implemented and the consistency and thoroughness of its use. Furthermore, adults with developmental disabilities and families have expressed frustration with the SIB-R's deficit based approach as opposed to using a strength-based approach consistent with current principles around best practice.

CWG is investigating the use of other methods of assessing the need for services and matching needs to resources including the InterRAI, Arizona's assessment /planning process, the Supports Intensity Scale (SIS) and others. While the SIS is better than the SIB-R in that it actually asks about services and supports the participant needs, instead of merely about their skills. However, it still assigns numbers to responses and yields a final overall supports score. Any evaluation that reduces the information about service needs to a single number (or 2 or 3 numbers) retains some of the objectionable features of the SIB-R.

InterRAI, however, continues to be a tool of high interest to the CWG. Work is underway to further understand its features. CWG envisions an opportunity to conduct an assessment resulting in an individual's need for resources based on an objective individual determination, rather than a score or a correlation. This will allow participants' broad flexibility and opportunity to make the best use of the resources to meet participant needs. While the CWG continues to study InterRAI, the DHW Division of Medicaid has committed staff resources to research and test assessment and resource allocation models, working actively with CWG to find the best statewide solution.

In addressing needs, "Natural Supports," or unpaid sources of assistance, may provide needed support and community integration for people with DD while reducing dependence on government financed services. Because "natural supports" are voluntary, they often are not predictable or reliable. CWG finds natural supports an underdeveloped resource in Idaho. However, the state does pay for support provided by family members, which may actually undermine the concept of natural supports. The issue and the resource warrant study and development.

A managed care organization model is designed for medical care; it would be difficult to develop a capitated managed care organization to appropriately serve the DD population.

A managed care organization (MCO) combines the functions of health insurance, delivery of care, and administration in a single organization. Typically, MCOs (such as health insurance companies) have considerable experience with medical care management. Medical managed care strategies rely on preventive treatment and care management to realize savings by reducing more expensive surgical and in-patient treatments.

DD services are very different from medical treatments and procedures. There is no reason to expect that the disability will be “cured” or that the participant will be rehabilitated to the level of complete independent functioning. DD services provide long-term supports for activities throughout the participant’s day and life span. Unlike medical procedures and therapies, DD services are not generally delivered in clinical settings and are most effective when they are integrated into home and community activities. DD services emphasize skill-building, adaptation, and supportive assistance rather than surgery, medication, and symptom control. Furthermore, federal requirements (and best practices) for individualized “person centered planning” and the ongoing supportive nature of DD services challenge the suitability of medical managed care models.

A couple states are experimenting with an MCO model in which a state agency (such as the Division of Developmental Disabilities) acts as an MCO. However, they must overcome the reality of the financial incentives built into MCO models, where a “per member per month” (PMPM) payment system may encourage the reduction of services without any incentives for improved outcomes. Idaho Medicaid services for people with DD already employ managed care strategies including prior authorizations, comprehensive services plans, care coordination, independent assessments, and individual service budgets. Some services, such as supported living and certified family homes, are already structured as capitated daily rates for comprehensive supports. The MCO feature Idaho has not adopted is a single capitated rate for the entire population. This is specifically because of the wide variations within the DD population. Some capitation features, including the limits on the total funding available in individual budgets, are featured in Idaho’s system. A high level of quality assurance is important for any DD service system, but it is even more important for managed care models.

In order to ensure Idaho’s funding is most appropriately budgeted for each individual, CWG finds that deploying a more effective assessment and resource allocation process will secure better outcomes than a capitated MCO contract structure.

2015 Initiatives

Community Inclusion

Collaborate on Home and Community Based Services Rules Implementation

In January 2014, the Center for Medicare and Medicaid Services (CMS) passed new final rules for the use of home and community-based Medicaid funding. The rule enhances quality, adds protections for individuals receiving services, ensures individuals have full access to the benefits of community living, are able to receive services in the most integrated setting, defines person-centered planning requirements, and provides for additional compliance options for waiver programs.⁴

Idaho's Division of Medicaid has already conducted a Gap Analysis and issued a Transition Plan for residential services to work toward the requirement of the new rules. The National Association of Councils on Developmental Disabilities has acknowledged Idaho for having produced one of, if not the most, responsive draft transition plans among the states.

Idaho also recently released the draft Transitional Plan for Non-residential settings.

Idaho is also fortunate in that it has an already established group—the CWG—to collaborate with the Division to implement the rules over the next five years. The CWG's vision for adults with DD is generally consistent with the new rules. The HCBS rules provide a framework for important parts of the DD system with which Idaho must comply. The CWG must ensure that the enhancements it proposes to the system are in compliance with these federal rules.

As the CMS HCBS rules are implemented, the Division of Medicaid is providing monthly updates to the CWG Steering committee on the status of transition planning and outreach to stakeholders. To ensure adults with developmental disabilities have a real voice in the implementation of the rules and reflect the actual impact, CWG members from the Council on Developmental Disabilities (ICDD), the Center on Disabilities and Human Development (CDHD), and Medicaid are working collaboratively to create a survey and conduct statewide focus groups with adults with developmental disabilities and families.

In addition to the statewide focus groups, ICDD and the CDHD are creating a statewide study of adults with significant disabilities to learn of their experiences with the implementation of the HCBS rules. The results of this study, along with information collected through the focus groups, will provide a wealth of information from people served by the developmental disabilities waiver. This baseline of information will then be provided to the Division of Medicaid for its

⁴ <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-01-10-2.html>

use in evaluating service provider compliance within the first year of HCBS rules implementation and in future years.

Revise the current assessment/resource allocation system to ensure that resources are effectively matched to actual individual needs and are aligned with the person centered planning process.

Much of CWG's current effort is in the study of needs assessment options and of interRAI specifically. CWG will continue to pursue this opportunity through 2015.

Enroll Idaho as a participant in the National Core Indicators Project™⁵

The National Core Indicators™ (NCI) is a voluntary effort by public developmental disabilities agencies to measure and track their own performance. Core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice and health and safety. Forty-two states have joined and are able to compare outcomes against each other's data. States participants report the acquisition of data that allows them to project future needs, trends, and where a state system may have a shortfall of available services to meet a growing demand.

The following table identifies the core indicators and what each addresses:

Core Indicator	Address
Individual Outcomes	How well the public system aids adults with developmental disabilities to work, participate in their communities, have friends and sustain relationships, and exercise choice and self-determination. Other indicators in this domain probe how satisfied individuals are with services and supports.
Health, Welfare and Rights	(a) Safety and personal security (b) Health and wellness (c) Protection of and respect for individual rights
System Performance	(a) Service coordination (b) Family and individual participation in provider-level decisions (c) The utilization of and outlays for various types of services and supports (d) Cultural competency (e) Access to services.
Staff Stability	Provider staff stability and competence of direct contact staff.
Family Indicators	How well the public system assists children and adults with developmental disabilities, and their families, to exercise choice and control in their decision-making, participate in their communities, and maintain family relationships. Additional indicators probe how satisfied families are with services and supports they receive, and how supports have affected their lives.

Table 2: National Core Indicators

⁵ <http://www.nationalcoreindicators.org/>

Idaho is one of thirteen states that have not joined NCI. With an acknowledged participation fee and need for Idaho staff resources, the CWG still finds participation in the NCI would prove advantageous to the state.

Generate a solid infrastructure, in coordination with University of Idaho's Center on Disabilities and Human Development (CDHD), providing the adult DD population an active, and effective voice in systems change

One of CWG's initiatives was to pursue a meaningful and consistent way to engage the adult DD population throughout the state and at all levels of functionality in systems change. CWG considers it essential for people with developmental disabilities are at the core of shaping their new service delivery system. While people with developmental disabilities have been involved throughout the work of the CWG, it was strongly felt that there was a need to be doing more to get a broader and deeper range of feedback from adults with developmental disabilities across the state.

Thanks to the leadership and expertise offered through CDHD, an important link through the policy, advocate and service levels of the DD population is being established.

CDHD houses the Coordinator for its own CDHD Community Advocacy Committee (CAC). The CAC's mission is to guide CDHD leaders by "providing insight into the opportunities and challenges facing people with disabilities and their families on national, state and local levels." The same person who holds the position as Coordinator for the CAC is also the state coordinator for the Idaho Self-Advocate Leadership Network (SALN). SALN is Idaho's statewide self-advocacy organization led by and for adults with developmental disabilities. SALN receives funds through a contract with the DD Council. SALN consists of a network of local chapters in Moscow, Nampa, Boise, Pocatello and Idaho Falls. Self-advocates participate in statewide and national self-advocacy education and participate on task forces developing state and national public policy. Members provide valuable insight into the lives of adults with developmental disabilities.

To help fulfill the objective for participant voices in CWG efforts, the CAC/SALN Coordinator now participates on the CWG Steering Committee. In that role, the Coordinator will use existing structures and processes to consistently engage adults with developmental disabilities in discussions about issues and ideas from the CWG. The process will capture opinions of adults with varying disabilities and from diverse geographical areas of the state.

The following lists additional initiatives CWG will pursue in 2015:

1. Create incentives for desired outcomes as opposed to units of service, and develop objective criteria and participant satisfaction measures to drive a robust quality assurance program.
2. Avoid administrative burdens created by compartmentalizing daily activities into multiple discreet billing codes and service definitions, to the extent allowed by federal Medicaid regulations.
3. Expand the use of current Medicaid models which allow for flexible and responsive supports such as the "My Voice, My Choice" (MVMC) option and Supported Living services.

4. Remove barriers and disincentives to using MVMC to access services from traditional service providers, and encourage systems that allow providers to offer service packages to participants.
5. Adopt an "Employment First" approach to services, encouraging employment to be considered in each person's planning process and incentivizing employment outcomes for people with DD.
6. Explore the opportunity for Medicaid to contract with Independent Living Centers to provide training to participants on navigating the service system, managing their own services, avoiding abuse and exploitation, and selecting providers.
7. Explore the opportunity for Medicaid to contract with Idaho Parents Unlimited (IPUL) to train parents and family members on selecting and managing services and supports.
8. Explore the opportunity for Medicaid to conduct frequent (annual if possible) review of provider rates and costs.
9. Explore how Medicaid may be able to increase the available training for providers.

CWG efforts will continue to seek increased flexibility and responsiveness in a manner integrated into the natural flow of participants' lives.

APPENDIX A: CHECKLIST

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Collaborative Adult Work Group System Changes Reference Checklist – 2013/2014 December 3, 2013

HOW TO USE THIS CHECKLIST

The following list of questions are to be used as a reference to help ensure proposed and implemented changes to the Adult Developmental Disabilities system respond to the needs, priorities and suggestions identified by the Collaborative Work Group. In posing these questions, the Collaborative Work Group recognizes regulatory requirements and fiscal constraints may affect the extent to which any of these can be implemented. However, Collaborative Work Group recommends any systems change consider how it does, to the extent feasible, best respond to the following questions. The goal is to intentionally improve the system to achieve the vision, and to specifically not harm what currently exists.

Subsequent pages provide a list of parameters respective to Medicaid rules and key definitions. Another checklist specific to participant needs, priorities and suggestions is pending.

In the development of our recommendations for and implementation of a Developmental Disabilities system for adults, have we ensured, to the extent possible . . .

- . . . a) the two eligibility processes include steps to effectively cross-reference other eligibility processes (Aged & Disabled Waiver, Developmental Disabilities Waiver, Intermediate Care Facilities for Individuals with Intellectual Disabilities, Intermediate Care Facilities for Individuals with Developmental Disabilities) with which an individual may also be involved?

- ... b) services (or service packages) are flexible and easy to adapt to an individual's changing needs?
- ... c) the individual budget process addresses all needs identified in the "person center planning" meeting, including those that fall outside of
 - a. "Medically necessary"? – *(See definitions below)*
 - b. "Health and safety"? - *(No definitions provided)*
- ... d) the individual budget process and person centered planning process work together to best meet individual needs?
- ... e) DHW clinical review processes collaborate more effectively with the person centered planning process? – *(See definitions below)*
- ... f) long-term employment supports are available to all individuals?
- ... g) specified services are governed by the same rules and regulations regardless of who is providing the service?
- ... h) reimbursement rates cover all costs incurred with providing services?
- ... i) billing procedures are structured in a user-friendly way that minimizes billing errors?
- ... j) regulations ...
 - ... 1) around data collection avoid duplication and enhance training?
 - ... 2) involving oversight of para-professional staff avoiding duplication and enhance training?
 - ... 3) allow services to include recreation and exercise?
 - ... 4) accommodations and additional dollars are in place to support services provided in rural areas?
- ... k) our provider network system offers career opportunities for both professionals and para-professionals featuring benefits, living wages and training?
- ... l) an effective communication system provides consistent information between different services?
- ... m) our system actively pursues a communication, outreach and information center that effectively brings best practices and progressive thought to all service providers and facilitates a shared understanding of the service delivery system?

Definitions

1. Person Centered Planning
2. Medically Necessary
3. Health and Safety
4. Quality Services
5. Quality Personnel

Definitions from Centers for Medicare & Medicaid Services Idaho Administrative Procedures Act:

Person Centered Planning

Centers for Medicare & Medicaid Services Technical Guide - An assessment and service planning process is directed and led by the individual, with assistance as needed or desired from a representative or other persons of the individual's choosing. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and nonpaid services and supports that assist him/her to achieve personally defined outcomes in the community.

Idaho Administrative Procedures Act - A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service.

Medically Necessary

Centers for Medicare & Medicaid Services Technical Guide - Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of the condition, and meet the standards of good medical practice

Idaho Administrative Procedures Act - A service is medically necessary if:

- a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and

- b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly.
- c. Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request.

Health and Safety, Quality Services and Quality Personnel – no specified definitions from Centers for Medicare & Medicaid Services or the Idaho Administrative Procedures Act

Medicaid Parameters

Medicaid is required to use CPT and HCBS procedure codes for billing. These codes are nationally recognized and are required by CMS. Each code comes with a description of the service. Instructions included as part of the description often identifies the minimum qualification of the provider and the billable unit.

Self-Direction services are not defined the same way and are therefore not subject to the same requirement.

Reimbursement rates are tied to the qualifications of the provider, and are established by the State of Idaho through a stated process.

Services purely diversional and recreational in nature fall outside the scope of HCBS wavier services. However, social and recreational programming is allowable. It is the intent of the service (socialization vs. diversion) that makes the difference.

Currently, medical necessity and health and safety requirements are a part of the exception review process. This criterion is applied to service requests that exceed the assigned budget. Exception review is attached to the current system – if redesigned, this may become moot.

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APPENDIX B: STATE MATRIX

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Supports and Services State Comparisons – pg 1

Current Services	Idaho 1915i	Michigan 1915 b/c <i>School age 26</i>	Arizona 1115, 1915K PCS-self dir.	Rhode Island 1115 Has wait list	New Mexico 1915i & 1915c	New York 1915 b/c?	Colorado 1915c	Wyoming 1915c Has Wait list 2-3 yrs	Oregon	North Carolina 1915 b/c
Adult Day Care	X	X <i>Waiver b/c</i>			X <i>C waiver?</i>		X <i>SLS waiver</i>	Looks like no	See dev. therapy	X
Behavioral & Crisis Mgt.	X	X <i>State plan</i>	X		X <i>C waiver</i>	X Clinics article 16	X <i>SLS waiver</i>		X	X
Chore Services	X	X <i>Waiver b/c</i>					X			
Developmental Therapy	X	X <i>Waiver b/c</i> includes pre-voc	X Day treatment	X Includes pre-voc	X <i>C waiver –</i> customized community	X Comm. & center Day services	X - SLS waiver Include pre-voc Spec. Habit. & Comm. Connection	X <i>waiver</i>	X pre-voc, comm. Acc. & day services	X Day supports, community networking
Emergency Response	X	X <i>Waiver b/c</i>		X w/in res support	X <i>C waiver</i>		X <i>SLS waiver</i>	X <i>waiver</i>		X
Environmental Modifications	X	X <i>Waiver b/c</i>	X	X <i>waiver</i>	X <i>C waiver</i>	X	X <i>SLS waiver</i> includes vehicles	X <i>waiver</i>		X
Home Choice (MFP)	X				X		X	X	X Community Transition	
Home Delivered Meals	X	X <i>Waiver b/c</i>					X <i>MFP - 2013</i>			
ICF/ID	X	X <i>State plan</i>	X Group home	X <i>Waiver</i> 24 hr res hab		X	X Group home 4-8	X <i>waiver</i>	X Group Home	X Group Home
Medication Mgt.	X	X <i>State plan</i>	X		X <i>State plan</i>	X	X <i>MFP - 2013</i>	X <i>Waiver</i> Tele-med	X	
Nursing Services	X	X <i>Waiver b/c</i>	X		X <i>C waiver</i>	X	X <i>MFP - 2013</i>	X <i>waiver</i>	X	
Therapies – OT, PT, Speech etc.	X	X <i>State plan</i>	X		X <i>State plan</i>		X <i>State plan</i>	X <i>waiver</i>	X	

Supports and Services State Comparisons – pg 2

Current Services	Idaho 1915i	Michigan 1915 b/c <small>School age 26</small>	Arizona 1115, 1915K PCS-self dir.	Rhode Island 1115 Has wait list	New Mexico 1915i & 1915c Has wait list	New York 1915 b/c?	Colorado 1915c	Wyoming Has Wait list 2-3 yrs	Oregon	North Carolina 1915 b/c
Personal Care Services	X	X <small>State plan</small>		X <small>waiver</small>			X <small>SLS waiver</small>	X <small>waiver</small>		X
Psycho- Therapy	X	X <small>State plan</small>	X			X	X		X <small>1915(i)</small>	
Psychosocial Rehab (PSR)	X	X <small>State plan</small>	X				X <small>MFP – 2013</small>		Not sure	
Residential Hab. Certified Family/ Supported Living	X	X <small>Comm. living b/c Home-based state plan</small>	X <small>Habilitation Adult dev. home</small>	X <small>Waiver Shared living & 24 hr res hab</small>	X <small>C waiver Special medical home</small>	X <small>Certified family & Supported living</small>	X <small>Certified family & Supported living</small>	X <small>Waiver Group & Indv. Group & Indv.</small>	X <small>Waiver</small>	X <small>In home skill building, intense support and res. support</small>
Respite	X	X <small>Waiver b/c</small>	X	X <small>Short term</small>	X <small>State plan</small>	X <small>Self-directed</small>	X <small>SLS waiver</small>	X <small>State plan</small>	X	X
Self-Directed Services	X	X <small>Waiver b/c Choice Voucher</small>	X		X <small>C waiver</small>	X <small>Includes respite</small>	X <small>Attendant in- home support</small>	X <small>Waiver Agency w/Choice</small>	X	X <small>2 models: Agency w/choice and Employ of Record</small>
Service Coordination	X	X <small>State plan</small>	X <small>waiver</small>	X <small>waiver</small>	X <small>State plan</small>	X	X <small>State plan?</small>	X <small>waiver</small>	X	X <small>Community Guide Services</small>
Specialized Medical Equip.	X	X <small>Waiver b/c</small>	X <small>waiver</small>	X <small>w/in res support</small>	X <small>C waiver</small>	X	X <small>SLS waiver & State plan</small>	X <small>waiver</small>	X	X
Supported Employment	X	X <small>(long term thru Med.)</small>	X	X	X <small>(also has self- employment)</small>	X	X	X	X	X
Transportation	X	X <small>State plan</small>	X		X <small>C waiver</small>	X	X	Looks like no	X	X

Other services offered not specific to DD - Adult foster Care - Idaho

Residential assisted living (A&D waiver) – Idaho and Arizona
Home Health Aid – Arizona
Hospice – Arizona

Supports and Services **Not** Offered in Idaho – pg 3

Current Services	Idaho 1915i	Michigan 1915 b/c <i>School age 26</i>	Arizona 1115, 1915K PCS-self dir.	Rhode Island 1115 Has wait list	New Mexico 1915i & 1915c Has wait list	New York 1915 b/c?	Colorado 1915c	Wyoming Has Wait list 2-3 yrs	Oregon	North Carolina 1915 b/c
Adult Ed. Supports						X				
Attendant Care			X							
Day Treatment for MI		X <i>State plan</i>								
Elderly DD targeted services						X				
Family Training		X <i>State plan</i>					X		X	
Homemaker			X	X			X <i>SLS waiver</i>	X <i>waiver</i>	X	
IBI for Autistics						X				
IRA Homes (up to 14)						X				
Mentorship							X			
Nutrition					X			X		
Counseling										
Residential for Non-waiver	Not sure which	State offers this								
Risk Screening for Inapp. Behaviors					X				X	
Socialization Sexuality					X				X	
Therapeutic recreation							X			

Note – other states allow individuals using the Self-Directed Waiver to purchase services from providers Idaho restricts this

North Carolina also offers: Assistive Technology Equipment and Supplies, Natural Supports Education, Vehicle Modifications and Specialized Consultation Services (i.e. Tele Consultation)

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APPENDIX C: ARIZONA STUDY SUMMARY

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**Arizona Fact-Finding Trip Report
to
Idaho's Collaborative Workgroup (CWG) on Services for Adults with
Developmental Disabilities
July 24, 2014**

CWG Arizona Fact-Finding Trip Report

In May 2014, a group of stakeholders from Idaho's Collaborative Workgroup (CWG) on Services for Adults with Developmental Disabilities visited Arizona to investigate their DD service delivery system. The stakeholders who visited Arizona included Christine Pisani, Bill Benkula, Art Evans, and Matthew Wappett. This trip included visits with state employees, policymakers, self-advocates, and families. This report outlines some of the key findings from this investigatory trip and provides backup documentation as an additional resource for consideration by the entire CWG.

Background

Arizona was one of the first states to create a comprehensive system for people with developmental disabilities committed to serving everyone eligible through an 1115 Medicaid Waiver (NASDDDS, 2010). Arizona has created a highly cost effective service system by moving away from large congregate settings and supporting individuals living with their families or in small community residences. As a result, Arizona is one of the most cost effective programs in the country, with only one state in the nation spending less per capita (NASDDDS, 2010). *The Case for Inclusion 2014* report put out by United Cerebral Palsy (UCP) ranked Arizona's Medicaid system for serving individuals with intellectual and developmental disabilities as #1 in the nation (UCP, 2014).

The Arizona Long Term Care System (ALTCS) serves over 34,970 people with developmental disabilities (AHCCCS, 2014). There has been steady growth in the program: from FY 2005 through FY 2013, enrollment in the DD program increased from 15,937 to 34,970 or 119.4%; of this amount approximately 26,000 receive long term care services, the other 8,900 individuals, who do not meet ALTCS eligibility, are served through a developmental disability "state only" funded program. This "state only" program provides for support coordination services and focuses on helping individuals find resources and natural supports in their communities. The annual budget for the ALTCS and "state only" program is approximately \$900 million.

Trip Agenda & Data Sources

Data that inform this report were derived from multiple conversations with stakeholders in Arizona. The data was primarily qualitative and taken from transcripts (see attached), notes, and personal recall by the participants on the fact-finding trip.

The agenda for the visits conducted on the Arizona trip was as follows:

Thursday, May 1, 2014

10:30 am Meeting with staff from Arizona Health Care Cost

	Containment System and the Division of Developmental Disabilities
12:15 pm	Lunch with Arizona DD Council Staff and Council Members
2:30 pm	Raising Special Kids - Parent meeting to discuss the AZ managed care model

Friday, May 2, 2014

10:00 am	Jon Meyers, Executive Director, The ARC of Arizona
11:00 am	Health & Wellness Fair - Disability Empowerment Center
1:00 pm	Meeting with participants of the service system
3:30 pm	Gompers Habilitation Center

General Findings and Observations

The AZ system has achieved much of their success through an 1115 R&D waiver (as opposed to a 1915(c) waiver, like Idaho). This allows them much more flexibility and leeway in how they manage their systems, define their cost methodology, and conduct quality assurance. The 1115 R&D waiver requires more reporting and oversight from CMS, but in the long run it has allowed Arizona to serve more people with disabilities in a more efficient manner. Much of what Arizona has accomplished would be difficult, and in some cases impossible, under a 1915(c) waiver.

AZ has a one-time assessment and qualification process. When an individual qualifies for the ALTCS program they do not have to go through annual reassessments or qualification processes. Arizona currently uses a person-centered planning model facilitated by care coordinators to identify individuals needs and to determine necessary services. Nevertheless, they are currently conducting a proof of concept pilot with the SIS this summer and are in contract talks with Arizona's two UCEDDs to take on the task of conducting annual assessments for ALTCS clients using the SIS. They are currently unsure of how the SIS assessment process would affect the budgeting process for clients.

Because they operate under an 1115 waiver AZ uses an individual cost neutrality model as opposed to an aggregate cost neutrality model like Idaho. Each client's needs and ISP is reviewed by AHCCS (the fiscal side of ALTCS) through a Cost Effectiveness Study (CES) to ensure that the costs for each person receiving services in the community does not exceed an institutional threshold for costs. The department reported that most adults with disabilities who qualify for the ALTCS program are living with their parents/families, which helps to keep costs contained. Arizona's narrow definition used for ALTCS eligibility also helps keep costs contained.

Another mechanism that Arizona uses for cost containment is the use of "shared risk agreements" with individuals with disabilities and their families. Arizona will rarely provide 24-hour monitoring or support services for individuals with significant medical conditions, even if a medical professional or the family feels that those services are necessary. ALTCS, through the care coordinator, will

negotiate an arrangement with the family where they will compromise on a "reasonable" amount of support and will then ask the family to assume the risk of monitoring the other times. For example, the state may provide for 12 hours a day of monitoring/support for an individual on a ventilator who requires constant adjustment and suction to keep the ventilator clear, and then Medicaid will ask the family to provide that support for the other 12 hours. The families sign a "shared risk agreement" that releases the state from liability for the time that the family is providing the support. Arizona Medicaid also uses these shared risk agreements for individuals who want to self-direct their own services or who want to live independently in the community. In the event there is no way to assure safety under the shared risk agreements model, and the individual requires 24 hour supports, Arizona does have several 6 to 8 bed group homes that are available but they are not licensed as ICF/IDs.

ALTCS clients have the ability to self-direct their services within a set of programmatic constraints. Clients can hire and fire staff through the use of a fiscal intermediary, but they are unable to pay them as they wish because all service rates are set by the state and cannot exceed institutional rates to ensure individual cost neutrality. As mentioned earlier, ALTCS will also use shared risk agreements to provide additional flexibility for clients who want to pursue activities and/or living arrangements that are not wholly supported through Medicaid. Medicaid contracts with an independent living center to provide extensive training called "This is My Life" to individuals with developmental disabilities. The training addresses the importance of speaking up, how to speak up, the service system, and many other topics related to controlling one's services and quality of life (see: <http://www.abil.org/this-is-my-life/>).

High quality care coordination/support brokerage is a linchpin to the success of the ALTCS system. State staff, advocacy organization personnel, parents, and self-advocates all commented on the importance of high quality care coordination in the ALTCS system. Care coordination is delivered directly by the State (i.e. care coordinators are State employees) and there is a strong focus on identifying and leveraging natural supports before bringing in paid supports. Care coordinators receive extensive and ongoing training from the Arizona Division on Developmental Disabilities (ADDD), and are constantly being monitored and evaluated by the ADDD (see attached ADDD Training Planning and Tracking Form for Support Coordinators). Care coordinators typically have caseloads of 50-60 clients.

Consumer satisfaction appears to be high for individuals who are in the system; although we did learn that it can be difficult for some individuals to get into the ALTCS system. This was evidenced by the fact that there are many legal firms that specialize in helping clients qualify for ALTCS. Self-advocates whom we spoke with informed us that it is NOT necessary to have attorneys assist when applying for services, but that many people are denied services because Arizona uses such a narrow definition for eligibility. Legal firms typically become

involved after people have been denied access; legal firms help individuals appeal their case, and provide assistance in arguing that the individuals does, in fact, meet the eligibility criteria and should be allowed access to the services available. For example Teresa Moore, a national self-advocate whom we met with, had no trouble applying for and accessing the ALTCS program, but her friend that also met with us, was denied access because he sustained his spinal cord injury in a car accident at age 16.

It became clear from our conversations that ALTCS and the State of Arizona were deeply committed to creating functional partnerships between the state agencies, advocacy organization, and provider groups. In addition to contracting with independent living centers to provide self-advocacy training, Arizona Medicaid also contracts with the Arizona Parent Training Center to provide parent training to learn about the service system, how to navigate the service system, and provides the ability to have parents involved in systems change and public policy discussions directly related to the service system. This center is also directly involved in the development of the training curriculum and the actual training of the care coordinators. Rates for providers are kept current by a very specific methodology of reviewing rates annually and doing a mandatory re-basing of rates every 5 years. Arizona uses the same method of setting rates as Idaho has in statute but in Idaho that method has never fully been implemented.

Guardianship appears to be encouraged within Arizona and there are self-service centers available to download all of the forms necessary to file for guardianship. This was a clear theme through our discussions with the state and with parents.

AZ places a high priority of data and specifically in their participation in the National Core Indicators project. The National Core indicators data provides robust data that helps them gauge their effectiveness and it assists the State in being proactive in planning for future needs. Although participating in the NCI did place an additional administrative burden on the State, the benefits far outweigh the costs of participation according to ALTCS personnel.

All of the people we met with mentioned that Arizona's service system was very urban-centric and that people residing in rural and remote areas (anywhere outside of the Phoenix/Scottsdale or Tucson areas) have limited access to quality services. Several people mentioned having to move closer to urban areas to receive the services and supports they needed.

Arizona has the largest American Indian population of any other state. Most of the tribal groups are located in the "Four Corners" area in the north of the state, although there are several large tribal groups located in the Phoenix area. All of the parties we spoke with mentioned the challenges inherent in delivering services to this rural population. We did learn that the "Four Corners" region has its' own protection and advocacy organization to assist tribal members in accessing services.

Idaho Council on Developmental Disabilities
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<http://www.icdd.idaho.gov/projects/Adult%20Services/ASR.html>

AMENDED AGENDA #2
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, February 12, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
RS23566	Physician procedures within proximity of admitting privileges	Chairman Heider
RS23603	Relating to the Health Quality Planning Council	Senator Schmidt
Docket No. 16-0201-1401	<i>Division of Public Health</i> - Rules of the Idaho Time Sensitive Emergency System Council	Dr. Bill Morgan, Chair Division of Public Health
Presentation	<i>Department of Health & Welfare</i> - Overview of Budget Request	Richard Armstrong, Director Department of Health and Welfare

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 12, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Nuxoll, Tippetts, Lee, Johnson (Lodge) and Schmidt

ABSENT/ EXCUSED: Senators Hagedorn and Lacey

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:01 p.m.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin.

RS 23566 **Chairman Lee Heider**, presented **RS 23566**. He stated the legislation came from doctors in his area. It requires doctors to have admitting privileges in a hospital within 20 miles of the facility where they perform an abortion. He said it was needed because outside doctors had been coming into his area, performing abortions and returning to Boise or elsewhere in the state leaving patients who were in critical condition. Those doctors had been counselling their patients to go to the hospital to have the emergency room doctors take care of them if they should have complications. **Chairman Heider** introduced Dr. David McClusky to tell his experiences and why the legislation was important.

Dr. David McClusky, M.D., General Surgeon, said he has practiced in Twin Falls since 1982 and has worked in the emergency rooms in Wood River, Jerome, and the Magic Valley. He has been on the Board of Medicine (Board) for the last six years and has held the office of chairman. He now sits on the Board's Committee on Physician Discipline where these issues come before him. He has also encountered the problem as an emergency room physician on a number of occasions. He strongly recommended support of **RS 23566**. He said it would direct those who deliver health care to make sure the patient was protected and make sure the people who performed the procedures had responsibility for the proper care of their patients. As an emergency room doctor he has done emergency hysterectomies, treated severe sepsis, and he almost lost a patient when the physician who did the procedure was not with the patient or available to talk to. He said when a surgeon operates on people, any complications caused by the operation should be corrected and helped by that surgeon.

Senator Tippetts asked Dr. McClusky if he characterized all abortions as surgical procedures. **Dr. McClusky** said yes because an abortion was an invasive procedure that could cause a bleeding problem or a perforation into the abdominal cavity. He said any procedure that invaded a person in that way was a surgical procedure.

Senator Lee said the Statement of Purpose (SOP) referred to surgical procedures, but the section was very specific on the type of surgical procedure. She asked Dr. McClusky if he saw cosmetic surgery or other invasive procedures being done by doctors without privileges. **Dr. McClusky** responded abortion was primarily the one they saw because most other procedures were done by local doctors. **Dr. McClusky** asked Chairman Heider to answer the question about the SOP.

Chairman Heider responded Idaho Code §§ 18-604 and 18-608 deal specifically with abortions. He said there were other sections of the code that this would apply to that may be equally important, but this section of code deals with abortion.

Senator Schmidt pointed out that on line 45, page 3, the description of surgical abortion did not quite fit because causing an abortion could be a medical procedure as opposed to a surgical procedure. He said he appreciated the legislation trying to promote continuity and wondered why it would not apply to other medical procedures. **Chairman Heider** responded §§ 18-604 and 18-608 dealt specifically with abortions, not with general surgery or other areas. It could be expanded if they saw a need.

Senator Nuxoll voiced a concern that Catholic hospitals were not supposed to allow doctors who perform abortions into their hospitals, and this amendment would require the hospitals to have admitting privileges for those doctors. It would violate conscience rights in a different way. **Dr. McClusky** replied he had honored the policies of Catholic hospitals where they did not allow tubal ligations and hysterectomies and realized this would be a concern. **Senator Nuxoll** said it might be resolved where there was more than one hospital within an area.

Senator Johnson (Lodge) asked how common it was for doctors who were not current residents of the area to come in to their hospital, and if they were performing abortions in local family planning clinics. **Dr. McClusky** said it depended upon the procedure. Abortion happened to be a procedure with doctors coming in from a distance.

Senator Tippetts said the SOP referred to surgical procedures but **RS 23566** was specific to abortions. He asked Chairman Heider if he would be opposed to amending the SOP to refer specifically to abortions and not surgical procedures in general. **Chairman Heider** said he would not be opposed to making it more exact.

Chairman Heider closed by reporting that 22 states have adopted similar legislation that has been upheld by the courts. He said he appreciated the Committee's consideration and hoped they would send **RS 23566** to print.

MOTION:

Senator Tippetts moved to print **RS 23566** with the understanding that the sponsor will bring in an amended SOP that refers specifically to abortion. **Senator Nuxoll** seconded the motion. The motion passed by **voice vote**.

RS 23603

Senator Dan Schmidt presented **RS 23603**. He announced a correction would need to be made to the SOP because it said Health Quality Planning Council and it should say Health Quality Planning Commission (Commission) as written in the Resolution.

Senator Schmidt said **RS 23603** was a resolution to direct the Commission to consider issues surrounding suicide in the State of Idaho. The Idaho Council on Suicide Prevention (Council) had certain recommendations for policy going forward. He thought it would be best to have the Commission consider the Council's policy recommendations and bring them back to the Committee in the coming year. **Senator Schmidt** asked the Committee to support and print **RS 23603**.

MOTION:

Senator Lee moved to print **RS 23603** with the change to the SOP striking Council and replacing it with Commission. **Senator Tippetts** seconded the motion. The motion passed by **voice vote**.

Dr. Bill Morgan, M.D., General Surgeon/Trauma Surgeon, St. Alphonsus Hospital Trauma Service, and Chairman of the Time Sensitive Emergency System Council (TSE) for the State of Idaho, presented **Docket No. 16-0201-1401**.

Dr. Morgan referred to Idaho Code § 56-1028 regarding the duties and rulemaking of the TSE. He said the 2014 Legislature approved and funded the TSE to develop, implement and monitor a voluntary statewide system of care for three of the top five causes of deaths in Idaho: traumas, strokes, and heart attacks. He said he will use the acronym for ST-elevation myocardial infarction (STEMI) in place of the word heart attack in the presentation. The purpose of the TSE is to develop and provide oversight for the system, set up regions in the State, and develop standards and procedures for designating centers and how they would interact with the TSE. The TSE designation would replace the American College of Surgeons (ACS) designation of trauma centers, facilitate acquisition of data points from those centers, and promulgate the rules.

Dr. Morgan explained the TSE Bylaws (see attachment 1) and the TSE System Standards Manual (see attachment 2).

Vice Chairman Martin thanked Dr. Morgan and others who worked on this since it was passed last year. He was pleased and impressed with how much they accomplished in that short period of time.

Senator Nuxoll asked why the centers were paying fees and where the money went. **Dr. Morgan** said the fees covered the cost of site surveys and reviews, supported the system, and provided the education the centers and EMS agencies needed. He said the fees had been vetted with the majority of the facilities and with the Idaho Hospital Association and were found to be fair and equitable. In comparison, the ACS would charge \$47,000 for site surveys to designate a center as a Level II Trauma Center. If a center designated with the State, they would not need to pay ACS fees or other stroke and STEMI system fees.

Senator Nuxoll remarked that the rural areas had a problem working with it at first and asked if those situations were taken care of. **Dr. Morgan** said the TSE had several meetings with the Idaho Hospital Association representative who interfaced with all the rural centers, and the TSE had addressed and answered all the questions to their satisfaction.

Senator Nuxoll asked if centers near the state lines that already had a designation from the neighboring state had to get both designations. **Dr. Morgan** said the rule states the TSE may provide reciprocity for facilities in Idaho that also choose to operate under a designation from a neighboring state system. This would account for Lewiston.

Senator Tippetts thanked Dr. Morgan for the effort that had been put in. He asked if the Notification of Loss of Certification or Licensure section was a mandate and suggested the language should be firmer to make it clear that it was an obligation by using the word "must". **Dr. Morgan** agreed.

Senator Tippetts said the language needed to be clarified in the Designation Fee Payment section that, in addition to notifying a facility of successfully meeting designation criteria, the TSE would notify a facility if they had failed to pass an on-site survey. **Senator Tippetts** then asked if there was a difference between the terminology "on-site survey" and "on-site review." **Dr. Morgan** said they were used interchangeably. **Senator Tippetts** said there were a few other things he would like to talk to Dr. Morgan about after the meeting.

Senator Nuxoll asked what would happen if an area did not want to pay the fees. **Dr. Morgan** said the entire system was set up as a voluntary system. If they chose not to participate, that would be fine.

Senator Nuxoll said she thought the fees would be an issue for some of the centers.

MOTION: **Chairman Heider** moved to approve **Docket No. 16-0201-1401**. **Senator Schmidt** seconded the motion. The motion passed by **voice vote**. **Senator Nuxoll** asked to be recorded as voting nay.

PRESENTATION: **Richard Armstrong**, Director, Department of Health and Welfare (DHW), presented the DHW Overview of Budget Request (see attachment 3). He introduced Tom Shanahan, Public Information Officer, DHW. He said other members of his senior management team were in the audience to answer questions if needed.

Director Armstrong stated this was a maintenance budget with several opportunities for smart governance. He said the overall budget had increased 3.3 percent which equalled almost \$83 million; however, if they subtracted the non-discretionary adjustments, the Change in Employee Compensation (CEC), employee benefit costs, and the State Healthcare Initiative Plan (SHIP) federal grant, the actual percentage increase was only around 1 percent.

The increase in receipts was 32 percent, mostly due to new federal regulations in Medicaid that required the DHW to collect an estimated two years of hospital settlements in fiscal year (FY) 2016. Medicaid continues to be four-fifths of the budget, which is similar to last year. A new change is a proposal to retitle Medical Indigency Program to Healthcare Policy Initiatives. He said The Medical Indigency Program funds their administrative activities to reduce the cost to the counties and the State for indigent healthcare.

The percentage distribution of their funding was largely unchanged from last year. He said 85 percent of the appropriated funding goes to the private sector for services and goods.

Director Armstrong said the evolution toward a more sustainable and effective healthcare system began in 2007. DHW became very involved with this initiative because Medicaid is one of the larger insurers in the State, covering almost 270,000 Idahoans. Many of Medicaid's participants have serious illnesses or disabilities that can result in very high costs. Because of this, DHW's early emphasis was to transition Medicaid participants to health homes and care management solutions. The health homes are extremely important for helping DHW manage expensive chronic conditions. For care management, Medicaid now has programs in transportation, dental, and behavioral health services. Their vision was to transition all Medicaid participants to care management so people would receive the most appropriate and evidence-based services at the right time and for the right cost.

Director Armstrong stated that in January Idaho was awarded the SHIP grant which was a 4-year grant for almost \$40 million. Idaho's SHIP proposal was based upon the patient-centered medical home for Medicaid patients. In this model, a primary care provider and team coordinated all of a patient's care. Medical homes made extensive use of electronic health records to track medications and tests. They also collected outcome data to evaluate how a patient's health had been affected by specific treatments. The payment model for patient-centered medical homes would change. Today, most insurers and Medicaid pay a straight fee-for-service claim for each treatment that is given. With the SHIP model, medical providers receive a per-member per-month fee for managing the care of the patients. He said other states were conducting similar reforms and showing great success.

Director Armstrong said DHW conducted a pilot of Medicaid adults with chronic diseases to see how a medical home affected their hospital use. During

the two-year pilot they reduced hospital admissions by 26 percent, hospital readmissions by 41 percent, and emergency room visits by 24 percent. They found patients were less likely to receive unnecessary tests or seek ER treatment for a non-emergency, and had fewer hospital admissions. With expanded use of electronic health records, their prescriptions were more easily monitored by their primary care physician so there were fewer adverse effects or prescription abuse. They are still analyzing the data, but overall they saved an average of 20 percent during the pilot. They paid the health home a monthly fee to manage the participants, with preliminary data showing a ten-to-one return on investment. The participants in the pilot were some of the most chronically ill and expensive patients who would greatly benefit from coordinated care management. With the general Medicaid population, DHW expected savings and improved outcomes as well, but probably not such a high rate of return as the pilot population.

Director Armstrong said the SHIP grant is for \$39.6 million spread over 4 years. DHW is asking for spending authority for \$8.9 million of the grant for FY 2016, which will be administered by the Healthcare Policy Initiatives Program. With that funding they will begin the transition of 165 primary care practices to the medical home model, targeting about one-third or 55 of those in 2016. They will also use grant funding to connect the practices' electronic health records to the Idaho Health Data Exchange, which was very important in managing patients and collecting outcome data. The Idaho model for the grant relies heavily on developing regional collaboratives to support local, coordinated care.

Director Armstrong presented DHW's supplemental FY 2015 General Fund budget requests:

- \$615,000 for the plaintiff attorney fees for the Jeff D lawsuit concerning children's mental health services that has been ongoing since 1980. DHW has been in confidential mediation since October 2013. A draft agreement is under review by all parties and they hoped it would come to conclusion this year.
- \$1.89 million for Hepatitis C treatment. He said this was a very expensive treatment costing at least \$100,000 per patient. State Medicaid programs are required to pay for FDA-approved drugs when medically necessary. There may be an opportunity to reduce this cost as new similar drugs come to the market. DHW is exploring those possibilities.
- \$796,700 for Access to Recovery Grant IV targeted at veterans in the criminal justice system, families involved with child protection in which part of their problem involves substance abuse, and the homeless population. The grant is expected to serve over 3,400 Idahoans with substance use disorders over the next 3 years.

Director Armstrong next presented DHW's FY 2016 requests from the General Fund:

- \$1.52 million for a second community crisis center. He said the Committee appropriated funds last Session for the development of a behavioral health crisis center which opened successfully in Idaho Falls last December. This year the Governor was recommending funding for a second crisis center. He said the purpose of a crisis center was to provide a safe, voluntary, effective and efficient alternative to emergency rooms and jails for people suffering a behavioral health crisis. Hospitals, counties, cities and the State should all realize savings. It could save on law enforcement resources, county indigent funds, emergency department services to uninsured patients and reduce court-ordered civil commitments.

Director Armstrong said DHW's contract with Bonneville County for operation of their crisis center required the county to develop a plan to cover 50 percent of the operating funds within 2 years. He explained it was critical DHW worked with communities opening crisis centers, so they contributed local funding to the greatest extent possible. Future crisis centers would have the same contract requirement.

- \$39,500 for Food Stamp Multi-Day Issuance. Last legislative session DFW agreed to extend their food stamp distribution from one day to ten days. They had been providing the benefit on the first day of each month, but will now go to the first ten days of each month. The annual cost was estimated at \$211,400 per year. Initially they would have one-time costs for computer programming, mailing of notices to participants, and new card embossing machines which would be covered with a bonus from high performance in the food stamp program.
- \$72,500 for the Health Facility Surveyors Program that licenses nursing homes, assisted living facilities, certified family homes and others. He said the program was having a difficult time retaining trained workers primarily due to stress and workload. They were working hard to improve productivity and efficiency, but were barely avoiding financial penalties for meeting federal performance standards. As of December 31, 2014, they had 235 overdue surveys and 135 open complaints that required investigation. They also anticipated conducting over 3,100 surveys during 2015. He said as baby boomers age, these types of facilities will grow and the work will continue to increase.
- \$279,000 for Community Hospitalization increase. The Community Hospitalization Program treats patients who are committed to the State and waiting for an open space to come available at the State Hospital. DHW negotiates with the hospitals individually, but overall it will be about a 10 percent increase. The hospitals are not renewing contracts at the current rates, but they agreed to short-term contract extensions while this request was being made.
- \$456,200 for adoption case load growth. **Director Armstrong** said DHW had been very successful in finding adoptive homes for children who cannot safely live with their families. Many of them had suffered from abuse and neglect, so finding adoptive families for them was a major victory. DHW provided a monthly stipend for these families because many of the children had special needs due to the abuse and neglect they suffered. DHW had experienced a decrease in federal funding which shifted some of the costs to the State. He said adoptions have a long-lived positive impact on children. The alternative is perpetual foster care until a child ages out at age 18, but that is not as positive and can be more expensive in the long run.
- \$111,200 for a laboratory staff pay increase for retention. **Director Armstrong** said DHW was experiencing a high rate of turnover among the scientists at the State Laboratory. An analysis showed that State Lab workers' average earnings were 23 percent less than the surrounding states and the private sector. The inability to retain public health scientists diminishes Idaho's ability to respond to health threats like influenza, rabies, anthrax, or Ebola. DHW would target the majority of funding for mid-level scientists and use some for hard to recruit positions.

- \$596,000 for TRICARE immunizations. **Director Armstrong** said Idaho assesses health insurers an amount per child they cover to purchase vaccines at a greatly reduced cost. TRICARE is a federal insurance program for military personnel and their families that is not authorized to pay into state vaccine assessments like other insurers. DHW is partnering with Washington to develop an equitable solution to keep from putting the children of military at risk.
- \$14.2 million for Your Health Idaho (YHI) for FY 2015 and FY 2016. **Director Armstrong** said DHW shares eligibility services with YHI. In November, Idaho implemented their own health insurance marketplace at less than half the cost of most states. In the first two months, Idaho became one of the most effectively operated exchanges in the country. He explained most states have struggled and failed due to the complexity of their eligibility systems. Idaho leveraged its high-functioning eligibility system to include the terminations for tax credits. They called the model Eligibility Shared Services. As of October 2014, YHI was approved for \$70 million in federal funds to build its exchange. The development cost for the exchange is expected to total \$14 million over a 2-year period. That explains DHW's request for receipt authority for YHI development costs along with ongoing operations. Shared services allowed Idaho to implement the exchange quickly and effectively, and also ensured they built Idaho's investment on proven technology minimizing risk and maximizing functionality. Throughout the process they have been careful to meet the legislative intent that no state funds would be used to implement Idaho's exchange. That was the Legislature's direction and it has been strictly adhered to.

By sharing eligibility services, Idaho was able to do what no other state accomplished in 2014. Idaho successfully converted from the federal marketplace to its own state-based exchange. One advantage they realized from the shared eligibility system was new data they will be able to glean along with determining tax credits for YHI. The system also determines eligibility for public assistance programs that include Medicaid, food stamps, cash and child care assistance. By analyzing system data that takes a global view of participants in each program, they have identified approximately 53,000 people below the poverty limit who are not receiving Medicaid or a tax credit. They are part of the gap population; Idaho citizens who have no access or options for health care.

Director Armstrong urged the support of the 3 percent salary increase recommended by the Governor this year. He said DHW had been working hard to reduce their turnover rate, but the rate had slightly increased in 2014. In exit interviews with workers taking jobs in the private sector, over half identified pay as the main or contributing factor to their decision to leave. Their average pay increase in the private sector was substantial, averaging 38 percent. Over 20 percent of the turnover in 2013 was workers who had less than 2 years of service, and 57 percent included workers with less than 6 years. DHW does not want to become the training ground for the private sector. It is expensive to train someone in a position just to see them leave as their skills reach a productive level. The workload remains high and they cannot afford to lose talented workers. He said the CEC was vital for DHW to retain their valuable workforce. He emphasized that DHW was still experiencing extremely high workloads as the economy was recovering and unemployment was going down.

Director Armstrong stated the number of Idahoans receiving public assistance remains high, even as unemployment rates fall. People are working, but they are not earning a livable wage and they still need public assistance. He said food stamps are often considered a barometer of the economy. When the economy went into the recession, unemployment more than doubled. Food stamp enrollment mirrored a similar increase delayed by several months. As the economy recovered and unemployment rates declined, enrollment in food stamps declined. At the same time, Medicaid enrollment steadily increased. Most of the new enrollees were children from low income households. So why the discrepancy between the two programs? With food stamps the single people went back to work and no longer needed assistance, but households with children were still struggling, not earning enough to meet the basic needs of the family.

Director Armstrong reported on how low wages impact self-sufficiency. He said the Idaho Department of Labor estimates the number of jobs that pay subsistence wages. For a family of 4, a subsistence wage in Idaho is estimated at \$20.30 an hour. Only 30 percent of Idaho jobs pay subsistence wages for a family of 4 and 70 percent do not. This is the reality DHW programs and workers are dealing with on a daily basis.

Director Armstrong concluded his remarks with the Public Assistance by Region 2014 Chart. The lowest users of public assistance were Regions 2 and 4; the highest were Regions 3 and 5. He said DHW had adapted their systems and procedures to handle the increased workloads, but the long-term answer would be a livable wage for Idaho workers. He pointed out that Governor Otter's Accelerate Idaho Strategic Plan would set the course for creating new opportunities for citizens and communities. He said he sensed a strong commitment in the Legislature for future economic growth, development, and education to fuel a vibrant, self-reliant workforce. DHW is confident they are on the right path and will continue to do everything they can to help citizens achieve self-reliance.

Vice Chairman Martin thanked Director Armstrong and invited questions.

Senator Nuxoll asked if there were different definitions of managed care. **Director Armstrong** said managed care was used in different ways. DHW refers to care management as a general term that oversees the health care delivery system or the engagement of the providers in the management of care at a detail level. He said there are many variations that change the way money is moved from a payer to a provider. DHW either uses fee-for-service or can pay into a collective delivery system in a community. **Senator Nuxoll** said she thought they had moved away from fee-for-service. **Director Armstrong** said DHW had moved four different programs off of fee-for-service, but physical medicine had not been moved yet. The four were transportation, dental, behavioral health, and dual eligible (people who are eligible for Medicare and Medicaid).

Senator Schmidt asked Director Armstrong if they expect the number of families with self-sufficient wages to come back up. **Director Armstrong** said he saw no evidence of it happening. Household income has continued to be fairly static while the cost of living has gone up. Idaho is probably 49th or 50th in the nation for household income. He said other states have improved their lot, but it hasn't happened here.

Chairman Heider asked Director Armstrong where and when the next behavioral health center would be opened, and what would be the cost savings. **Director Armstrong** said they had to follow public purchasing protocol by refreshing the Request for Proposal they sent out last year to determine the location and time frame. Their goal was seven centers in the future. DHW would be happy to do one or more a year depending on funding from the Legislature. He said they had only been operational for two months, so he was not ready to report on expected savings. He said the new center was doing exactly what they wanted, and they will have good hard statistics for the Committee.

Senator Johnson (Lodge) asked why there was such a disparity between Region 3 with the highest need for public assistance and Region 4 with the lowest need, when many residents of Region 3 drove to Region 4 for employment. **Director Armstrong** responded that Region 3 had been a significant commuting community into Boise; however, they were not commuting for high paying jobs. The cost of living was lower in Region 3, so some of the folks who earn less had migrated west to find housing.

**PASSED THE
GAVEL:**

Vice Chairman Martin passed the gavel back to Chairman Heider.

ADJOURNED:

There being no further business, **Chairman Heider** adjourned the meeting at 3:31 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Paula Tonkin
Assistant Secretary

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Time Sensitive Emergency System Standards Manual

State of Idaho

Authority: Sections 56-1024 through 56-1030, Idaho Code



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Monday through Friday (except holidays designated by the State of Idaho)

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I. DEFINITIONS

The following terms used in this manual as defined below:

Heart attack. STEMI, which is a common name for ST-elevation myocardial infarction, a more precise definition for a type of heart attack that is caused by a prolonged period of blocked blood supply that affects a large area of the heart and has a substantial risk of death and disability calling for a quick response.

Regional Time Sensitive Emergency (TSE) Committee. A regional TSE committee established under Section 56-1027, Idaho Code.

Stroke. An interruption of blood flow to the brain causing paralysis, slurred speech and/or altered brain function usually caused by a blockage in a blood vessel that carries blood to the brain (ischemic stroke) or by a blood vessel bursting (hemorrhagic).

Trauma. The result of an act or event that damages, harms, or hurts a human being resulting in intentional or unintentional damage to the body resulting from acute exposure to mechanical, thermal, electrical, or chemical energy, or from absence of such essentials as heat or oxygen.

TSE Designated Center. A facility that has voluntarily applied for TSE designation, met and is in compliance with the designation criteria and standards of these rules when published, and that the TSE Council has designated as one (1) or more of the following:

- a. Trauma
 - (1) Adult Level I Trauma Center;
 - (2) Adult Level II Trauma Center;
 - (3) Adult Level III Trauma Center;
 - (4) Adult Level IV Trauma Center;
 - (5) Adult Level V Trauma Center;
 - (6) Pediatric Level I Trauma Center; or
 - (7) Pediatric Level II Trauma Center.
- b. Stroke (when published)
 - (1) Comprehensive Stroke Center
 - (2) Primary Stroke Center
 - (3) Acute Stroke Ready Center
- c. STEMI (Heart Attack) (when published)
 - (1) Receiving STEMI Center
 - (2) Referring STEMI Center

TSE system. Under Section 57-2002, Idaho Code, The organized approach to treating injured patients that establishes and promotes standards for patient transportation, equipment, and information analysis for effective and coordinated TSE care. TSE systems represent a continuum of care that is fully integrated into the emergency medical services system and is a coordinated effort between out-of-

hospital providers with the close cooperation of medical specialists in each phase of care. The focus is on prevention, coordination of acute care, and aggressive rehabilitation. Systems are designated to be inclusive of all patients with a TSE requiring acute care facilities, striving to meet the needs of the patient, regardless of the severity of injury, geographic location or population density. A TSE system seeks to prevent injuries from happening and the reduction of death and disability when they do happen.

II. TSE STANDARDS MANUAL AUTHORITY

The Idaho Time Sensitive Emergency System Council is authorized under Section 56-1028, Idaho Code, to promulgate rules for the purpose of establishing standards and for the administration of a voluntary time sensitive emergency system of care.

III. REFERENCED DOCUMENTS

- American College of Surgeons, Resources for the Optimal Care of the Injured Patient, 2006

IV. TSE REGIONS

TSE Regions

There are six TSE regions.

- **Region 1 – North.** The counties of Benewah, Bonner, Boundary, Kootenai, Latah, and Shoshone.
- **Region 2 – North Central.** The counties of Clearwater, Idaho, Latah, Lewis and Nez Perce.
- **Region 3 – Southwest.** The counties of Ada, Adams, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington.
- **Region 4 – South Central.** The counties of Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls.
- **Region 5 – Southeast.** The counties of Bannock, Bear Lake, Bingham, Caribou, Cassia, Franklin, Minidoka, Oneida, and Power.
- **Region 6 – East.** The counties of Bingham, Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison, and Teton.

The specific procedures to request realignment of regions can be found section 81 of the Rules of the Idaho Time Sensitive Emergency System Council. Refer to Section 56-1030, Idaho Code for detailed description of the Regional TSE Committee functions.

V. APPLICATION PROCESS

General Information

A facility applying for initial designation as a TSE designated facility must apply for each designation by submitting the following to the TSE:

- A completed application for each designation being sought;
- A non-refundable TSE site survey fee; and
- Scheduling a site survey as applicable.

Fees

The designation fees are for a three (3) year designation and are payable on an annual basis.

Trauma Designations	Designation Fee 3-years/Annual (Not to exceed)	TSE On-Site Survey Fee (Not to exceed)
Level I	\$45,000/\$15,000	\$3,000 (Not applicable if using ACS verification)
Level II	\$36,000/\$12,000	\$3,000 (Not applicable if using ACS verification)
Level III	\$24,000/\$8,000	\$3,000 (Not applicable if using ACS verification)
Level IV	\$12,000/\$4,000	\$1,500 (Not applicable if using ACS verification)
Level V	\$3,000/\$1,000	\$1,500
Pediatric Level I and Level II	\$36,000/\$12,000	Not applicable because of ACS verification

Site Survey

A TSE Council site survey may include:

- A review of the facility's application;
- Chart review based on the facility's application;
- Inspection of equipment pertaining to the designation being sought;
- Review of policies and procedures pertaining to the designation being sought;
- A physical inspection of the facility;
- Interviews with facility staff and review of staff credentials;
- A review of the facility's protocols and call schedules;
- A review of transfer protocols; and
- A review of the facility's planned interaction with pre-hospital transport.

Survey Team

A TSE Council approved site survey team may include:

A physician reviewer:

- will be certified by the American Board of Medical Specialties or the American Board of Osteopathic Medicine;
- will be board certified in the specialty area he/she is representing on the review team;
- be currently active in trauma, stroke or emergency cardiac care at a center that is at or above the level being reviewed;
- for Trauma Level I and Level II, be from out-of-state; and
- Have no conflict of interest with the center under review.

Nurse Reviewer and/or Program Manager:

- be currently active in trauma, stroke or emergency cardiac care at a center that is at or above the level being reviewed;
- for Trauma Level I and Level II, be from out-of-state; and
- have no conflict of interest with the center under review.

The procedures to notify the TSE Council of a potential conflict of interest with a specific reviewer can be found in section 251 of the Rules of the Idaho Time Sensitive Emergency System Council.

Waivers, Denials, Modification, Revocation and Suspension

Procedures for applying for a waiver or for submitting an appeal can be found in the TSE Rules, sections 270-285.

VI. TRAUMA DESIGNATION

Level I, II, III & Level IV

Hospitals seeking Level I, II, III or Level IV trauma designation have the choice to use the ACS or the State of Idaho to verify their compliance with the standards published in the ACS document: Resources for the Optimal Care of the Injured Patient, 2006, or with standards incorporated by the TSE Council for state designation.

To apply for Level I, II, III or Level IV, using the ACS to verify compliance, the following is required:

- A completed application;
- A copy of the pre-review questionnaire (PRQ) from the ACS; and
- A copy of the ACS site review

To apply for Level I, II, III or Level IV, using the Idaho TSE Council to verify compliance, the following is required:

- A completed application;
- A non-refundable site survey fee; and
- Schedule a site survey.

A hospital applying for initial designation that is using the Idaho TSE Council to verify compliance must have a TSE Council approved survey team evaluation prior to initial designation as a TSE designated facility as a Level I, II, III or Level IV trauma center. The hospital must meet or exceed the designation criteria in Appendix A.

Once verified by the ACS or the Idaho TSE Council, and approved by the TSE Council, the center will be designated for three (3) years, unless the designation is rescinded by the TSE Council for non-compliance to the TSE Council's rules. Designation fee for year one must be paid prior to receipt of the designation from the TSE Council. Yearly designation fees must be submitted within thirty (30) days of receipt of invoice in order to maintain designation.

Any TSE designated center that has a loss of certification or licensure will immediately notify the TSE Council.

A TSE designated Level III or Level IV trauma center requesting renewal of their designation must:

- Submit a renewal application three months prior to the expiration date of the previous designation;
- Submit TSE site survey fee, if applicable, and
- Submit a copy of the full ACS report detailing the results of the ACS site visit; or
- Schedule a site visit from a TSE Council approved survey team. (Designation will not be rescinded due to a delay in scheduling the site visit if the delay is through no fault of the facility.)

Level V

A hospital, free standing emergency department, or rural clinic seeking Level V trauma designation must undergo the Idaho TSE Council verification to demonstrate compliance with the standards incorporated by that council.

To apply for Level V, the following is required:

- A completed application;
- TSE site survey fee; and
- Schedule a site survey.

A facility applying for initial designation must have a TSE Council approved survey team evaluation prior to initial designation as a TSE designated facility as a Level V trauma center. The facility must meet or exceed the designation criteria in Appendix A.

Once verified, the center will be designated for three (3) years, unless the designation is rescinded by the TSE Council for non-compliance with the rules and/or standards. Designation fee for year one must be paid prior to receipt of the designation from the TSE Council.

Any TSE designated center that has a loss of certification or licensure (by the Joint Commission or State of Idaho) for any reason will immediately notify the TSE Council.

A TSE designated Level V Trauma Center requesting renewal of their designation must:

- Submit a renewal application within three months of the expiration date of the previous designation;
- Submit TSE site survey fee; and
- Schedule a site visit from a TSE Council approved survey team. (Designation will not be rescinded due to a delay in scheduling the site visit if the delay is through no fault of the facility.)

Pediatric Trauma

Hospitals seeking Pediatric Level I or II Trauma Center designation must undergo the American College of Surgeons' (ACS) verification to demonstrate compliance with the corresponding standards published in the ACS document: Resources for Optimal Care of the Injured Patient, 2006 or 2015 as applicable.

To apply for Pediatric Level I or II Trauma Center, the following is required:

- A completed application;
- A copy of the pre-review questionnaire (PRQ) submitted to the ACS; and
- A copy of the ACS site survey.

Once verified by the ACS, and approved by the TSE Council, the center will be designated for three (3) years, unless the designation is rescinded by the TSE Council for non-compliance to the TSE Council's rules.

Any TSE designated center that has a loss of certification or licensure (by the Joint Commission or State of Idaho) for any reason will immediately notify the TSE Council.

A TSE designated Pediatric Level I or II Trauma Center requesting renewal of their designation must:

- Submit a renewal application;
- Be verified by the ACS 3 months prior to the expiration date of previous designation; and
- Submit a copy of the full ACS report detailing the results of the ACS site visit.

VII. APPENDIX A: DESIGNATION REQUIREMENTS

Level I Trauma Center

Designation Criteria for Level I Trauma Center

Criteria for designation of Level I trauma centers are based upon *Resources for Optimal Care of the Injured Patient, COT/American College of Surgeons, 2006*. Criteria to verify the services and systems are in place to ensure optimal care of the trauma patient are defined in that document. The following elements must be met for designation as a Level I trauma center in Idaho.

Criteria Element
1. Trauma Systems
1.1 There is sufficient involvement by the hospital trauma program staff in state/regional trauma system planning, development, and/or operation.
2. Description of Trauma Centers and Their Roles in a Trauma System
2.1 There is surgical commitment to the trauma center.
2.2 All trauma facilities are on the same campus.
2.3 The Level I trauma center meets admission volume performance requirements.
2.4 The trauma director has a responsibility and authority for determining each general surgeon's ability to participate on the trauma panel through the trauma PIPS program and hospital policy.
2.5 General surgeon or appropriate substitute is available for major resuscitations in house 24 hours a day.
2.6 The PIPS program has defined conditions requiring the surgeon's immediate hospital presence.
2.7 The 80% compliance of the surgeon's presence in the ED is confirmed and monitored by PIPS (30 minutes).
2.8 The trauma surgeon on call is dedicated to the trauma center wall on duty.
2.9 A published backup call schedule for trauma surgery is available.
2.10 Trauma surgeons in adult trauma centers that treat more than 100 injured children annually are credentialed for pediatric trauma care by the hospital's credentialing body.
2.11 The adult trauma center that treats more than 100 injured children annually has a pediatric ED area, a pediatric intensive care area, appropriate resuscitation equipment, and pediatric-specific trauma PIPS program.
2.12 The adult trauma center that treats children reviews the care of injured children through the PIPS program.
3. Prehospital Trauma Care
3.1 The trauma director is involved in the development of the trauma center's bypass protocol.
3.2 The trauma surgeon is involved in the decisions regarding bypass.
3.3 The trauma program participates in prehospital care protocol development and the PIPS program.
4. Interhospital Transfer
4.1 A mechanism for direct physician-to-physician contact is present for arranging patient transfer.



4.2 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient, for example, payment is not considered.

5. Hospital Organization and the Trauma Program

5.1 The hospital has the commitment of the institutional governing body and the medical staff to become a trauma center.

5.2 There is a current resolution supporting the trauma center from the hospital board.

5.3 There is a current resolution supporting the trauma center from the medical staff.

5.4 The multidisciplinary trauma program continuously evaluates its process and outcomes to insure optimal and timely care.

5.5 The trauma medical director is a board-certified surgeon or an ACS Fellow.

5.6 The trauma medical director participates in trauma call.

5.7 The trauma director is current in ATLS.

5.8 The trauma director is both a member and an active participant in a national or regional trauma organization.

5.9 The trauma director has the authority to correct deficiencies in trauma care or to exclude from trauma call the trauma team members who do not meet specified criteria.

5.10 The criteria for graded activation is clearly defined by the trauma center and continuously evaluated by the PIPS program.

5.11 Programs that admit more than 10% of injured patients to nonsurgical services demonstrate the appropriateness of that practice through the PIPS process.

5.12 Seriously injured patients are admitted to or evaluated by an identifiable surgical service staffed by credentialed trauma providers.

5.13 There is sufficient infrastructure and support to the trauma service to ensure adequate provision of care.

5.14 In teaching facilities, the requirements of the Residency Review Committee are met.

5.15 The trauma program manager shows evidence of educational preparation (a minimum of 16 hours of trauma-related continuing education per year) and clinical experience of injured patients.

5.16 There is a multidisciplinary peer review committee chaired by the trauma medical director or designee, with representatives from appropriate subspecialty services.

5.17 Adequate (>50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented.

5.18 The core group is adequately defined by the trauma medical director.

5.19 The core group takes at least 60% of the total trauma call hours each month.

5.20 The trauma director ensures and documents dissemination of information and findings from the peer review meetings to the noncore surgeons on the trauma call panel.

5.21 There is a Trauma Program Operational Process Performance Improvement Committee.

6. Clinical Functions: General Surgery

6.1 The trauma medical director has the responsibility and authority to ensure compliance with verification requirements

6.2 The general surgeon is board-certified and meets the Alternative Pathway and is an ACS Fellow.

6.3 The trauma surgeon has privileges in general surgery.

6.4 The trauma surgeon on call is dedicated to the trauma center while on duty.



6.5 A published backup call schedule for trauma surgery is available.
6.6 An attendance threshold of 80% is met for trauma surgeon presence in the ED.
6.7 The criteria for the highest level of activation is clearly defined and evaluated by the PIPS program.
6.8 A mechanism for documenting trauma surgeon presence in the operating room for all trauma operations is in place.
6.9 There is a multidisciplinary peer review committee with participation from general surgery, orthopedic surgery, neurosurgery, emergency medicine, and anesthesia.
6.10 Adequate (at least 50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented.
6.11 All general surgeons on the trauma team have successfully completed the ATLS course at least once.
6.12 The trauma medical director has documented 16 hours annually or 48 hours in three years of verifiable, external trauma related CME.
6.13 Other trauma surgeons who take trauma call have the documented 16 hours annually or 48 hours in 3 years of trauma-related CME or an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.
6.14 The trauma medical director is a member and participates in regional or national trauma organizations.
7. Clinical Functions: Emergency Medicine
7.1 The ED has a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients.
7.2 ED physicians are present in the ED at all times.
7.3 In institutions in which there are emergency medicine residency training programs, supervision is provided by an in-house attending emergency physician 24 hours per day.
7.4 The roles of emergency physicians and trauma surgeons are defined, agreed on, and approved by the director of trauma services.
7.5 An emergency physician is board-certified and meets the Alternate Pathway.
7.6 Emergency physicians on the call panel are regularly involved in the care of injured patients.
7.7 A representative from the ED participates in the prehospital PIPS program.
7.8 A designated emergency physician is available to the trauma director for PIPS issues that occur in the ED.
7.9 There is emergency physician participation with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee (dealing with systems issues).
7.10 The emergency medicine representative or designee to the multidisciplinary peer review committee attends a minimum of 50% of these meetings.
7.11 The emergency physician liaison representative has the documented 16 annually or 48 hours in 3 years of verifiable, external trauma-related CME.
7.12 Other emergency physicians who take trauma call have the documented 16 hours annually or 48 hours in 3 years of trauma-related CME and participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.
7.13 There are emergency physicians who have successfully completed the ATLS course.



7.14 Physicians who are not board-certified in emergency medicine who work in the ED are current in ATLS.

8. Clinical Functions: Neurosurgery

8.1 A neurosurgical liaison is designated.

8.2 Neurotrauma care is promptly and continuously available for severe traumatic brain injury and spinal cord injury and for less severe head and spine injuries when necessary.

8.3 The hospital provides an on-call neurosurgical backup schedule with formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed.

8.4 There is a PIPS review of all neurotrauma patients who are diverted or transferred.

8.5 An attending neurosurgeon is promptly available to the hospital's trauma service when the neurosurgical consultation is requested.

8.6 The neurosurgeons who care for trauma patients are board-certified and meet the Alternate Pathway.

8.7 Qualified neurosurgeons are regularly involved in the care of head- and spinal cord- injured patients and are credentialed by the hospital with general neurosurgical privileges.

8.8 The neurosurgery service participates actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.

8.9 The neurosurgeon representative attends a minimum of 50% of the multidisciplinary peer review committee meetings.

8.10 The neurosurgeon liaison representative has the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.

8.11 Other neurosurgeons who take trauma call have the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME and participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.

9. Clinical Functions: Orthopedic Surgery

9.1 Physical and occupational therapists and rehabilitation specialists are present.

9.2 Operating rooms are promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization and compartment decompression.

9.3 A mechanism to ensure operating room availability without undue delay for patients with semi urgent orthopedic injuries.

9.4 There is an orthopedic surgeon who is identified as the liaison to the trauma program.

9.5 Plastic surgery, hand surgery, and spinal injury care capabilities are present.

9.6 Orthopedic team members have dedicated call at their institution and a backup call system.

9.7 An orthopedic team member is promptly available in the trauma resuscitation area when consulted by the surgical trauma team leader for multiple injured patients.

9.8 The design of the backup call system, the responsibility of the orthopedic trauma liaison, has been approved by the trauma program director.

9.9 Provide sufficient resources, including instruments, equipment, and personnel, for modern musculoskeletal trauma care, with readily available operating rooms for musculoskeletal trauma procedures.



9.10 The orthopedic service participates actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.
9.11 The orthopedic trauma liaison or representative attends a minimum of 50% of the multidisciplinary peer review meetings.
9.12 Orthopedic surgeons who care for injured patients are board-certified and meet the Alternate Pathway.
9.13 The orthopedic surgeon has privileges in general orthopedic surgery.
9.14 The orthopedic surgical liaison to the trauma program has documented at least 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.
9.15 The orthopedic trauma team member has documentation of the acquisition of 16 hours of CME per year on average and has participated in an internal educational process conducted by the trauma program and the orthopedic liaison based on the principles of practice-based learning and the PIPS program.
10. Collaborative Clinical Services
Anesthesia
10.1 Anesthesia services are promptly available for emergency operations.
10.2 Anesthesia services are promptly available for airway problems.
10.3 There is an anesthesiologist liaison designated to the trauma program.
10.4 Anesthesia services are available in-house 24 hours a day.
10.5 When anesthesiology chief residents or CRNAs are used to fulfill availability requirement, the staff anesthesiologist on call is (1) advised, (2) promptly available at all times, and (3) present for all operations.
10.6 The availability of the anesthesia services and the absence of delays in airway control or operations are documented in the hospital PIPS process.
10.7 All anesthesiologists taking call have successfully completed a residency program.
10.8 The anesthesia liaison is identified.
10.9 The anesthesia representative participates in the trauma PIPS program.
10.10 The anesthesia representative or designee to the trauma program attends at least 50% of the multidisciplinary peer review meetings.
Operating Room
10.11 The operating room is adequately staffed and immediately available.
10.12 The operating room team does not have functions requiring its presence outside the operating room.
10.13 There is a mechanism for providing additional staff for a second operating room when the first operating room is occupied.
10.14 The operating room has the essential equipment.
10.15 Trauma centers have the necessary equipment for a craniotomy.
10.16 The trauma center has cardiopulmonary bypass and an operating microscope available 24 hours per day.
Post anesthesia Care Unit (PACU)
10.17 The PACU has qualified nurses available 24 hours per day as needed during the patient's post anesthesia recovery phase.



10.18 The PACU is covered by a call team from home with documentation by the PIPS program that nurses are available and delays are not occurring.
10.19 The PACU has the necessary equipment to monitor and resuscitate patients.
10.20 The PIPS process ensures that the PACU has the necessary equipment to monitor and resuscitate patients.
Radiology
10.21 Radiologists are promptly available, in person or by teleradiology, when requested, for the interpretation of radiographs, performance of complex imaging studies, or interventional procedures.
10.22 Diagnostic information is communicated in a written form and in a timely manner.
10.23 Critical information is verbally communicated to the trauma team.
10.24 Final reports accurately reflect communications, including changes between preliminary and final interpretations.
10.25 Changes in interpretation are monitored by the PIPS program.
10.26 There is at least 1 radiologist appointed as liaison to the trauma program.
10.27 Radiology participates in the trauma PIPS program by at least being involved in the protocol development and trend analysis that relate to diagnostic imaging.
10.28 The trauma center has policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the radiology department.
10.29 Conventional radiography and CT are available 24 hours per day.
10.30 There is an in-house radiographer.
10.31 There is an in-house CT technologist.
10.32 Conventional catheter angiography and sonography are available 24 hours per day.
10.33 MRI capability is available 24 hours per day.
10.34 The PIPS program documents the appropriate timeliness of the arrival of the MRI technologist.
Critical Care
10.35 There is a surgically directed ICU physician team.
10.36 The surgical director or codirector of the ICU has appropriate training and experience for the role.
10.37 The trauma surgeon remains in charge of patients in the ICU.
10.38 Physician coverage of critically ill trauma patients is available 24 hours per day.
10.39 Physicians covering critically ill trauma patients respond rapidly to urgent problems as they arise.
10.40 The surgical director of the ICU has obtained critical care training during residency or fellowship and has expertise in perioperative and postinjury care of injured patients.
10.41 The surgical director of the ICU has added qualifications in surgical critical care from the American Board of Surgery and meets the Alternate Pathway for critical care.
10.42 The trauma service retains responsibility for patients and coordinates all therapeutic decisions appropriate for its level.
10.43 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team.
10.44 The patient in Level I facilities have in-house physician coverage for ICU at all times.
10.45 A qualified nurse is available 24 hours a day to provide care during the ICU phase.



10.46 The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU.
10.47 The ICU has the necessary equipment to monitor and resuscitate patients.
10.48 Intracranial pressure monitoring equipment is available.
Other Surgical Specialists
10.49 The Level I facility has available a full spectrum of specialists.
Medical Consultants
10.50 The trauma center includes the following medical specialists: cardiology, infectious disease, pulmonary medicine, and nephrology and their respective support teams (for example, respiratory therapy, dialysis team, and nutrition support).
10.51 A respiratory therapist is available to care for trauma patients 24 hours per day.
10.52 Acute hemodialysis is available.
10.53 Laboratory services are available 24 hours per day for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate.
10.54 The blood bank is capable of blood typing and cross-matching.
10.55 The blood bank has an adequate amount of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, or appropriate coagulation factors to meet the needs of injured patients.
10.56 The capability for coagulation studies, blood gases, and microbiology are present.
11. Rehabilitation
11.1 The hospital has either rehabilitation services within its facility or a transfer agreement to a freestanding rehabilitation hospital.
11.2 The hospital has physical therapy services.
11.3 The hospital has social services.
11.4 The hospital has occupational therapy services.
11.5 The hospital has speech therapy services.
11.6 Rehabilitation consulting services, occupational therapy, speech therapy, physical therapy, and social services are available during the acute phase of care.
12. Trauma Registry
12.1 Trauma registry data are collected and analyzed.
12.2 The data are submitted to the National Trauma Data Bank.
12.3 The trauma center uses the registry to support its PIPS program.
12.4 The trauma registry has at least 80% of the trauma cases entered within 180 days of treatment.
12.5 The trauma program ensures that trauma registry confidentiality measures are in place.
12.6 There are strategies for monitoring data validity for the trauma registry.
13. Performance Improvement and Patient Safety (PIPS)
13.1 The trauma center demonstrates a clearly defined PIPS program for the trauma population.
13.2 The PIPS program is supported by a reliable method of data collection that consistently gathers valid and objective information necessary to identify opportunities for improvement.
13.3 The program is able to demonstrate that the trauma registry supports the PIPS process.
13.4 The process of analysis includes multidisciplinary review.
13.5 The process of analysis occurs at regular intervals to meet the needs of the program.
13.6 The results of analysis define corrective strategies.



13.7 The results of analysis and corrective strategies are documented.
13.8 The trauma program is empowered to address issues that involve multiple disciplines.
13.9 The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.
13.10 The trauma program has a medical director with the authority and administrative support to lead the program.
13.11 The trauma medical director has sufficient authority to set qualifications for the trauma service members.
13.12 The trauma director has the authority to recommend changes for the trauma panel based on performance review.
13.13 Identified problem trends undergo multidisciplinary peer review by the Trauma Peer Review Committee.
13.14 The trauma center is able to separately identify the trauma patient population for review.
13.15 There is a process to address trauma program operational issues.
13.16 There is documentation reflecting the review of operational issues and, when appropriate, the analysis and proposed corrective actions.
13.17 The process identifies problems.
13.18 The process demonstrates problem resolution (loop closure).
13.19 There is a trauma multidisciplinary peer review committee with participation by the trauma medical director or designee and representatives from general surgery, orthopedic surgery, neurosurgery, emergency medicine, and anesthesia.
13.20 The attendance by the trauma medical director and the specialty representatives is greater than 50%.
13.21 The core general surgeon attendance at the trauma peer review committee is greater than 50%.
13.22 In circumstances when attendance is not mandated (noncore members), the trauma medical director ensures dissemination of information from the trauma peer review committee.
13.23 The trauma medical director documents the dissemination of information from the trauma peer review committee.
13.24 Evidence of appropriate participation and acceptable attendance is documented in the PIPS process.
13.25 Deaths are systematically categorized as preventable, nonpreventable, or potentially preventable.
13.26 When a consistent problem or inappropriate variation is identified, corrective actions are taken and documented.
14. Outreach and Education
14.1 The trauma center is engaged in public and professional education.
14.2 The trauma center does provide some means of referral and access to trauma center resources.
14.3 The trauma center is involved in prevention activities, including public education activities.
14.4 The Level I trauma center provides an ATLS course at least annually.



14.5 The Level I trauma center provides a continuous rotation in trauma surgery for senior residents that is part of an Accreditation Council for Graduate Medical Education- accredited program in any of the following disciplines: general surgery, orthopedic surgery, or neurosurgery; and supports an acute care surgery fellowship consistent with the educational requirements of the American Association for the Surgery of Trauma.

14.6 The hospital provides a mechanism for trauma-related education for nurses involved in trauma care.

14.7 All general surgeons and emergency medical physicians on the trauma team have successfully completed the ATLS course at least once.

14.8 The trauma director and the liaison representatives from neurosurgery, orthopedic surgery, and emergency medicine have accrued an average of 16 hours annually or 48 hours in 3 years of external trauma-related CME.

14.9 Other general surgeons, neurosurgeons, orthopedic surgeons, and emergency medicine specialists who take trauma call have acquired 16 hours of CME per year on average or participated in an internal educational process.

15. Prevention

15.1 The trauma center participates in injury prevention.

15.2 The trauma center has a prevention coordinator with a demonstrated job description and salary support.

15.3 The trauma center demonstrates the presence of prevention activities that center on priorities based on local data.

15.4 The trauma center demonstrates collaboration with or participation in national, regional, or state programs.

15.5 The trauma center has the capability to provide intervention or referral for patients identified as problem drinkers.

16. Trauma Research and Scholarship

16.1 The Level I trauma center meets the minimum 20 peer-reviewed articles published in journals included in *Index Medicus* in 3 years or the criterion of 4 of 7 scholarly activities listed in chapter 19 and 10 peer-reviewed articles published in journals included in *Index Medicus* in 3 years.

16.2 The research resulted from work related to the trauma center.

16.3 The articles include authorship or co-authorship by a member of the general surgical team.

16.4 Of the 20 articles, there is at least 1 that includes authorship or co-authorship by members of the general surgery team and at least 1 each from 3 of 6 disciplines: neurosurgery, emergency medicine, orthopedics, radiology, anesthesia, and rehabilitation.

16.5 The trauma center meets the alternative criteria for research:

10 peer-reviewed articles published in journals included in *Index Medicus* resulting from work in the trauma center with at least 1 each from 3 of 6 disciplines (neurosurgery, emergency medicine, orthopedics, radiology, anesthesia, and rehabilitation); AND

4 of 7 scholarly activities as stated in Chapter 19, Trauma Research and Scholarship.

16.6 The administration of the trauma center demonstrates support of the research program.

17. Disaster Planning and Management

17.1 The hospital meets the disaster-related requirements of the Joint Commission.

17.2 A trauma panel surgeon is a member of the hospital's disaster committee.
17.3 Hospital drills that test the individual hospital's disaster plan are conducted at least every six months.
17.4 The trauma center has a hospital disaster plan described in the hospital disaster manual.
18. Organ Procurement Activities
18.1 The trauma center has an established relationship with a recognized OPO.
18.2 There are written policies for triggering notification of the OPO.
18.3 The PIPS process reviews the organ donation rate.
18.4 There are written protocols for declaration of brain death.



Designation Criteria for Level II Trauma Center

Criteria for designation of Level II trauma centers are based upon *Resources for Optimal Care of the Injured Patient, COT/American College of Surgeons, 2006*. Criteria to verify the services and systems are in place to ensure optimal care of the trauma patient are defined in that document. The following elements must be met for designation as a Level II trauma center in Idaho.

Criteria Element
1. Trauma Systems
1.1 There is sufficient involvement by the hospital trauma program staff in state/regional trauma system planning, development, and/or operation.
2. Description of Trauma Centers and Their Roles in a Trauma System
2.1 There is surgical commitment to the trauma center.
2.2 All trauma facilities are on the same campus.
2.4 The trauma director has a responsibility and authority for determining each general surgeon's ability to participate on the trauma panel through the trauma PIPS program and hospital policy.
2.6 The PIPS program has defined conditions requiring the surgeon's immediate hospital presence.
2.7 The 80% compliance of the surgeon's presence in the ED is confirmed and monitored by PIPS (30 minutes)
2.8 The trauma surgeon on call is dedicated to the trauma center wall on duty.
2.9 A published backup call schedule for trauma surgery is available.
2.10 Trauma surgeons in adult trauma centers that treat more than 100 injured children annually are credentialed for pediatric trauma care by the hospital's credentialing body.
2.11 The adult trauma center that treats more than 100 injured children annually has a pediatric ED area, a pediatric intensive care area, appropriate resuscitation equipment, and pediatric-specific trauma PIPS program.
2.12 The adult trauma center that treats children reviews the care of injured children through the PIPS program.
3. Prehospital Trauma Care
3.1 The trauma director is involved in the development of the trauma center's bypass protocol.
3.2 The trauma surgeon is involved in the decisions regarding bypass.
3.3 The trauma program participates in prehospital care protocol development and the PIPS program.
4. Interhospital Transfer
4.1 A mechanism for direct physician-to-physician contact is present for arranging patient transfer.
4.2 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient, for example, payment is not considered.
5. Hospital Organization and the Trauma Program
5.1 The hospital has the commitment of the institutional governing body and the medical staff to become a trauma center.

5.2 There is a current resolution supporting the trauma center from the hospital board.
5.3 There is a current resolution supporting the trauma center from the medical staff.
5.4 The multidisciplinary trauma program continuously evaluates its process and outcomes to ensure optimal and timely care.
5.5 The trauma medical director is a board-certified surgeon or an ACS Fellow.
5.6 The trauma medical director participates in trauma call.
5.7 The trauma director is current in ATLS.
5.8 The trauma director is both a member and an active participant in any national or regional trauma organizations.
5.9 The trauma director has the authority to correct deficiencies in trauma care or to exclude from trauma call the trauma team members who do not meet specified criteria.
5.10 The criteria for graded activation is clearly defined by the trauma center and continuously evaluated by the PIPS program.
5.11 Programs that admit more than 10% of injured patients to nonsurgical services demonstrate the appropriateness of that practice through the PIPS process.
5.12 Seriously injured patients are admitted to or evaluated by an identifiable surgical service staffed by credentialed trauma providers.
5.13 There is sufficient infrastructure and support to the trauma service to ensure adequate provision of care.
5.14 In teaching facilities, the requirements of the Residency Review Committee are met.
5.15 The trauma program manager shows evidence of educational preparation (a minimum of 16 hours of trauma-related continuing education per year) and clinical experience of injured patients.
5.16 There is a multidisciplinary peer review committee chaired by the trauma medical director or designee, with representatives from appropriate subspecialty services.
5.17 Adequate (>50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented.
5.18 The core group is adequately defined by the trauma medical director.
5.19 The core group takes at least 60% of the total trauma call hours each month.
5.20 The trauma director ensures and documents dissemination of information and findings from the peer review meetings to the noncore surgeons on the trauma call panel.
5.21 There is a Trauma Program Operational Process Performance Improvement Committee.
6. Clinical Functions: General Surgery
6.1 The trauma medical director has the responsibility and authority to ensure compliance with verification requirements
6.2 The general surgeon is board-certified and meets the Alternative Pathway and is an ACS Fellow.
6.3 The trauma surgeon has privileges in general surgery.
6.4 The trauma surgeon on call is dedicated to the trauma center while on duty.
6.5 A published backup call schedule for trauma surgery is available.
6.6 An attendance threshold of 80% is met for trauma surgeon presence in the ED.
6.7 The criteria for the highest level of activation is clearly defined and evaluated by the PIPS program.



6.8 A mechanism for documenting trauma surgeon presence in the operating room for all trauma operations is in place.
6.9 There is a multidisciplinary peer review committee with participation from general surgery, orthopedic surgery, neurosurgery, emergency medicine, and anesthesia.
6.10 Adequate (at least 50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented.
6.11 All general surgeons on the trauma team have successfully completed the ATLS course at least once.
6.12 The trauma medical director has documented 16 hours annually or 48 hours in three years of verifiable, external trauma related CME.
6.13 Other trauma surgeons who take trauma call have the documented 16 hours annually or 48 hours in 3 years of trauma-related CME or an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.
6.14 The trauma medical director is a member and participates in regional or national trauma organizations.
7. Clinical Functions: Emergency Medicine
7.1 The ED has a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients.
7.2 Emergency physicians cover in-house emergencies with a PIPS process demonstrating the efficacy of this practice.
7.3 In institutions in which there are emergency medicine residency training programs, supervision is provided by an in-house attending emergency physician 24 hours per day.
7.4 The roles of emergency physicians and trauma surgeons are defined, agreed on, and approved by the director of trauma services.
7.5 An emergency physician is board-certified and meets the Alternate Pathway.
7.6 Emergency physicians on the call panel are regularly involved in the care of injured patients.
7.7 A representative from the ED participates in the prehospital PIPS program.
7.8 A designated emergency physician is available to the trauma director for PIPS issues that occur in the ED.
7.9 There is emergency physician participation with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee (dealing with systems issues).
7.10 The emergency medicine representative or designee to the multidisciplinary peer review committee attends a minimum of 50% of these meetings.
7.11 The emergency physician liaison representative has the documented 16 annually or 48 hours in 3 years of verifiable, external trauma-related CME.
7.12 Other emergency physicians who take trauma call have the documented 16 hours annually or 48 hours in 3 years of trauma-related CME and participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.
7.13 There are emergency physicians who have successfully completed the ATLS course.
7.14 Physicians who are not board-certified in emergency medicine who work in the ED are current in ATLS.
8. Clinical Functions: Neurosurgery



8.1 A neurosurgical liaison is designated.
8.2 Neurotrauma care is promptly and continuously available for severe traumatic brain injury and spinal cord injury and for less severe head and spine injuries when necessary.
8.3 The hospital provides an on-call neurosurgical backup schedule with formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed.
8.4 There is a PIPS review of all neurotrauma patients who are diverted or transferred.
8.5 An attending neurosurgeon is promptly available to the hospital's trauma service when the neurosurgical consultation is requested.
8.6 The neurosurgeons who care for trauma patients are board-certified and meet the Alternate Pathway.
8.7 Qualified neurosurgeons are regularly involved in the care of head- and spinal cord- injured patients and are credentialed by the hospital with general neurosurgical privileges.
8.8 The neurosurgery service participates actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.
8.9 The neurosurgeon representative attends a minimum of 50% of the multidisciplinary peer review committee meetings.
8.10 The neurosurgeon liaison representative has the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.
8.11 Other neurosurgeons who take trauma call have the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME and participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program,
9. Clinical Functions: Orthopedic Surgery
9.1 Physical and occupational therapists and rehabilitation specialists are present.
9.2 Operating rooms are promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization and compartment decompression.
9.3 A mechanism to ensure operating room availability without undue delay for patients with semi urgent orthopedic injuries.
9.4 There is an orthopedic surgeon who is identified as the liaison to the trauma program.
9.5 Orthopedic team members have dedicated call at their institution and a backup call system.
9.6 An orthopedic team member is promptly available in the trauma resuscitation area when consulted by the surgical trauma team leader for multiple injured patients.
9.7 The design of the backup call system, the responsibility of the orthopedic trauma liaison, has been approved by the trauma program director.
9.8 Provide sufficient resources, including instruments, equipment, and personnel, for modern musculoskeletal trauma care, with readily available operating rooms for musculoskeletal trauma procedures.
9.9 The PIPS process reviews the appropriateness of the decision to transfer or retain major orthopedic trauma.
9.10 The orthopedic service participates actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.



9.11 The orthopedic trauma liaison or representative attends a minimum of 50% of the multidisciplinary peer review meetings.
9.12 Orthopedic surgeons who care for injured patients are board-certified and meet the Alternate Pathway.
9.13 The orthopedic surgeon has privileges in general orthopedic surgery.
9.14 The orthopedic surgical liaison to the trauma program has documented at least 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.
9.15 The orthopedic trauma team member has documentation of the acquisition of 16 hours of CME per year on average and has participated in an internal educational process conducted by the trauma program and the orthopedic liaison based on the principles of practice-based learning and the PIPS program.
10. Collaborative Clinical Services
Anesthesia
10.1 Anesthesia services are promptly available for emergency operations.
10.2 Anesthesia services are promptly available for airway problems.
10.3 There is an anesthesiologist liaison designated to the trauma program.
10.4 When CRNAs are used to fulfill availability requirement, the staff anesthesiologist on call, if available, is (1) advised, (2) promptly available for consult at all times, and (3) present for all operations if requested by the CRNA.
10.5 The availability of the anesthesia services and the absence of delays in airway control or operations are documented in the hospital PIPS process.
10.6 Anesthesia services are available 24 hours a day and present for all operations.
10.7 In trauma centers without in-house anesthesia services, protocols are in place to ensure the timely arrival at the bedside of the anesthesia provider.
10.8 In a center without anesthesia services, there is documentation of the presence of physicians skilled in emergency airway management.
10.9 All anesthesiologists taking call have successfully completed a residency program.
10.10 The anesthesia liaison is identified.
10.11 The anesthesia representative participates in the trauma PIPS program.
10.12 The anesthesia representative or designee to the trauma program attends at least 50% of the multidisciplinary peer review meetings.
Operating Room
10.13 There is a mechanism for providing additional staff for a second operating room when the first operating room is occupied.
10.14 The operating room is adequately staffed and readily available.
10.15 The PIPS program evaluates the operating room availability and delays when an on-call team is used.
10.16 The operating room has the essential equipment.
10.17 Trauma centers have the necessary equipment for a craniotomy.
Post anesthesia Care Unit (PACU)
10.18 The PACU has qualified nurses available 24 hours per day as needed during the patient's post anesthesia recovery phase.



10.19 The PACU is covered by a call team from home with documentation by the PIPS program that nurses are available and delays are not occurring.
10.20 The PACU has the necessary equipment to monitor and resuscitate patients.
10.21 The PIPS process ensures that the PACU has the necessary equipment to monitor and resuscitate patients.
Radiology
10.22 Radiologists are promptly available, in person or by teleradiology, when requested, for the interpretation of radiographs, performance of complex imaging studies, or interventional procedures.
10.23 Diagnostic information is communicated in a written form and in a timely manner.
10.24 Critical information is verbally communicated to the trauma team.
10.25 Final reports accurately reflect communications, including changes between preliminary and final interpretations.
10.26 Changes in interpretation are monitored by the PIPS program.
10.27 There is at least 1 radiologist appointed as liaison to the trauma program.
10.28 Radiology participates in the trauma PIPS program by at least being involved in the protocol development and trend analysis that relate to diagnostic imaging.
10.29 The trauma center has policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the radiology department.
10.30 Conventional radiography and CT are available 24 hours per day.
10.31 There is an in-house radiographer.
10.32 When the CT technologist responds from outside the hospital, the PIPS program documents response time.
10.33 Conventional catheter angiography and sonography are available 24 hours per day.
Critical Care
10.34 The trauma center has a surgical director or codirector for the ICU who is responsible for setting policies and administration related to trauma ICU patients.
10.35 The trauma surgeon remains in charge of patients in the ICU.
10.36 Physician coverage of critically ill trauma patients is available 24 hours per day.
10.37 Physicians covering critically ill trauma patients respond rapidly to urgent problems as they arise.
10.38 The trauma service retains responsibility for patients and coordinates all therapeutic decisions appropriate for its level.
10.39 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team.
10.40 Coverage of emergencies in the ICU leaves that ED with appropriate physician coverage.
10.41 A qualified nurse is available 24 hours a day to provide care during the ICU phase.
10.42 The patient:nurse ratio does not exceed 2:1 for critically ill patients in the ICU.
10.43 The ICU has the necessary equipment to monitor and resuscitate patients.
10.44 Intracranial pressure monitoring equipment is available.
Other Surgical Specialists
10.45 The Level II Center has required surgical specialists.



Medical Consultants
10.46 Specialists from internal medicine and pulmonary medicine are available on staff.
10.47 Specialty consultations for problems related to internal medicine, pulmonary medicine, cardiology, gastroenterology, and infectious disease are available.
10.48 A respiratory therapist is available to care for trauma patients 24 hours per day.
10.49 A Level II center has either dialysis capabilities or a transfer agreement.
10.50 Nutrition support services are available.
10.51 Laboratory services are available 24 hours per day for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate.
10.52 The blood bank is capable of blood typing and cross-matching.
10.53 The blood bank has an adequate amount of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, or appropriate coagulation factors to meet the needs of injured patients.
10.54 The capability for coagulation studies, blood gases, and microbiology are present.
11. Rehabilitation
11.1 The hospital has either rehabilitation services within its facility or a transfer agreement to a freestanding rehabilitation hospital.
11.2 The hospital has physical therapy services.
11.3 The hospital has social services.
11.4 The hospital has occupational therapy services.
11.5 The hospital has speech therapy services.
11.6 Rehabilitation consulting services, occupational therapy, speech therapy, physical therapy, and social services are available during the acute phase of care.
12. Rural Trauma Care
12.1 A rural Level II center provides the same level of care as a nonrural Level II.
12.2 The PIPS process demonstrates the appropriate care or response by providers.
13. Trauma Registry
13.1 Trauma registry data are collected and analyzed.
13.2 The data are submitted to the National Trauma Data Bank.
13.3 The trauma center uses the registry to support its PIPS program.
13.4 The trauma registry has at least 80% of the trauma cases entered within 180 days of treatment.
13.5 The trauma program ensures that trauma registry confidentiality measures are in place.
13.6 There are strategies for monitoring data validity for the trauma registry.
14. Performance Improvement and Patient Safety (PIPS)
14.1 The trauma center demonstrates a clearly defined PIPS program for the trauma population.
14.2 The PIPS program is supported by a reliable method of data collection that consistently gathers valid and objective information necessary to identify opportunities for improvement.
14.3 The program is able to demonstrate that the trauma registry supports the PIPS process.
14.4 The process of analysis includes multidisciplinary review.
14.5 The process of analysis occurs at regular intervals to meet the needs of the program.
14.6 The results of analysis define corrective strategies.
14.7 The results of analysis and corrective strategies are documented.



14.8 The trauma program is empowered to address issues that involve multiple disciplines.
14.9 The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.
14.10 The trauma program has a medical director with the authority and administrative support to lead the program.
14.11 The trauma medical director has sufficient authority to set qualifications for the trauma service members.
14.12 The trauma director has the authority to recommend changes for the trauma panel based on performance review.
14.13 Identified problem trends undergo multidisciplinary peer review by the Trauma Peer Review Committee.
14.14 The trauma center is able to separately identify the trauma patient population for review.
14.15 There is a process to address trauma program operational issues.
14.16 There is documentation reflecting the review of operational issues and, when appropriate, the analysis and proposed corrective actions.
14.17 The process identifies problems.
14.18 The process demonstrates problem resolution (loop closure).
14.19 There is a trauma multidisciplinary peer review committee with participation by the trauma medical director or designee and representatives from general surgery, orthopedic surgery, neurosurgery, emergency medicine, and anesthesia.
14.20 The attendance by the trauma medical director and the specialty representatives is greater than 50%.
14.21 The core general surgeon attendance at the trauma peer review committee is greater than 50%.
14.22 In circumstances when attendance is not mandated (noncore members), the trauma medical director ensures dissemination of information from the trauma peer review committee.
14.23 The trauma medical director documents the dissemination of information from the trauma peer review committee.
14.24 Evidence of appropriate participation and acceptable attendance is documented in the PIPS process.
14.25 Deaths are systematically categorized as preventable, nonpreventable, or potentially preventable.
14.26 When a consistent problem or inappropriate variation is identified, corrective actions are taken and documented.
15. Outreach and Education
15.1 The trauma center is engaged in public and professional education.
15.2 The trauma center does provide some means of referral and access to trauma center resources.
15.3 The trauma center is involved in prevention activities, including public education activities.
15.4 The hospital provides a mechanism for trauma-related education for nurses involved in trauma care.
15.5 All general surgeons and emergency medical physicians on the trauma team have successfully completed the ATLS course at least once.



15.6 The trauma director and the liaison representatives from neurosurgery, orthopedic surgery, and emergency medicine have accrued an average of 16 hours annually or 48 hours in 3 years of external trauma-related CME.
15.7 Other general surgeons, neurosurgeons, orthopedic surgeons, and emergency medicine specialists who take trauma call have acquired 16 hours of CME per year on average or participated in an internal educational process.
16. Prevention
16.1 The trauma center participates in injury prevention.
16.2 The trauma center has a prevention coordinator with a demonstrated job description and salary support.
16.3 The trauma center demonstrates the presence of prevention activities that center on priorities based on local data.
16.4 The trauma center demonstrates collaboration with or participation in national, regional, or state programs.
16.5 The trauma center has the capability to provide intervention or referral for patients identified as problem drinkers.
17. Disaster Planning and Management
17.1 The hospital meets the disaster-related requirements of the Joint Commission.
17.2 A trauma panel surgeon is a member of the hospital's disaster committee.
17.3 Hospital drills that test the individual hospital's disaster plan are conducted at least every six months.
17.4 The trauma center has a hospital disaster plan described in the hospital disaster manual.
18. Organ Procurement Activities
18.1 The trauma center has an established relationship with a recognized OPO.
18.2 There are written policies for triggering notification of the OPO.
18.3 The PIPS process reviews the organ donation rate.
18.4 There are written protocols for declaration of brain death.



Designation Criteria for Level III Trauma Center

Criteria for designation of Level III trauma centers are based upon *Resources for Optimal Care of the Injured Patient, COT/American College of Surgeons, 2006*. Criteria to verify the services and systems are in place to ensure optimal care of the trauma patient are defined in that document. The following elements must be met for designation as a Level III trauma center in Idaho.

Criteria Element
1. Trauma Systems
1.1 There is sufficient involvement by the hospital trauma program staff in state/regional trauma system planning, development, and/or operation.
2. Description of Trauma Centers and Their Roles in a Trauma System
2.1 There is surgical commitment to the trauma center.
2.2 All trauma facilities are on the same campus.
2.3 The trauma director has a responsibility and authority for determining each general surgeon's ability to participate on the trauma panel through the trauma PIPS program and hospital policy.
2.4 The 80% compliance of the surgeon's presence in the ED is confirmed and monitored by PIPS (30 minutes)
2.5 Has continuous general surgical coverage.
2.6 The trauma panel surgeons respond promptly to activations, remain knowledgeable in trauma care principles whether treating locally or transferring to a center with more resources, and participate in performance review activities.
2.7 Has well defined transfer plans.
2.8 Trauma surgeons in adult trauma centers that treat more than 100 injured children annually are credentialed for pediatric trauma care by the hospital's credentialing body.
2.9 The adult trauma center that treats more than 100 injured children annually has a pediatric ED area, a pediatric intensive care area, appropriate resuscitation equipment, and pediatric-specific trauma PIPS program.
2.10 The adult trauma center that treats children reviews the care of injured children through the PIPS program.
3. Prehospital Trauma Care
3.1 The trauma director is involved in the development of the trauma center's bypass protocol.
3.2 The trauma surgeon is involved in the decisions regarding bypass.
3.3 The trauma program participates in prehospital care protocol development and the PIPS program.
4. Interhospital Transfer
4.1 A mechanism for direct physician-to-physician contact is present for arranging patient transfer.
4.2 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient, for example, payment is not considered.
5. Hospital Organization and the Trauma Program

5.1 The hospital has the commitment of the institutional governing body and the medical staff to become a trauma center.
5.2 There is a current resolution supporting the trauma center from the hospital board.
5.3 There is a current resolution supporting the trauma center from the medical staff.
5.4 The multidisciplinary trauma program continuously evaluates its process and outcomes to ensure optimal and timely care.
5.5 The trauma medical director is a board-certified surgeon or an ACS Fellow.
5.6 The trauma medical director participates in trauma call.
5.7 The trauma director is current in ATLS.
5.8 The trauma director has the authority to correct deficiencies in trauma care or to exclude from trauma call the trauma team members who do not meet specified criteria.
5.9 The criteria for graded activation is clearly defined by the trauma center and continuously evaluated by the PIPS program.
5.10 Programs that admit more than 10% of injured patients to nonsurgical services demonstrate the appropriateness of that practice through the PIPS process.
5.11 The structure of the trauma program allows the trauma director to have oversight and authority for care of the injured patients who may be admitted to individual surgeons.
5.12 There is a method to identify injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners.
5.13 There is a multidisciplinary peer review committee chaired by the trauma medical director or designee, with representatives from appropriate subspecialty services.
5.14 Adequate (>50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented.
5.15 The core group is adequately defined by the trauma medical director.
5.16 The core group takes at least 60% of the total trauma call hours each month.
5.17 The trauma director ensures and documents dissemination of information and findings from the peer review meetings to the noncore surgeons on the trauma call panel.
5.18 There is a Trauma Program Operational Process Performance Improvement Committee.
6. Clinical Functions: General Surgery
6.1 The trauma medical director has the responsibility and authority to ensure compliance with verification requirements
6.2 The trauma surgeon has privileges in general surgery.
6.3 An attendance threshold of 80% is met for trauma surgeon presence in the ED.
6.4 The criteria for the highest level of activation is clearly defined and evaluated by the PIPS program.
6.5 A mechanism for documenting trauma surgeon presence in the operating room for all trauma operations is in place.
6.6 There is a multidisciplinary peer review committee with participation from general surgery, orthopedic surgery, neurosurgery, emergency medicine, and anesthesia.
6.7 Adequate (at least 50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented.
6.8 All general surgeons on the trauma team have successfully completed the ATLS course at least once.
7. Clinical Functions: Emergency Medicine



7.1 The ED has a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients.
7.2 Emergency physicians cover in-house emergencies with a PIPS process demonstrating the efficacy of this practice.
7.3 In institutions in which there are emergency medicine residency training programs, supervision is provided by an in-house attending emergency physician 24 hours per day.
7.4 The roles of emergency physicians and trauma surgeons are defined, agreed on, and approved by the director of trauma services.
7.5 Emergency physicians on the call panel are regularly involved in the care of injured patients.
7.6 A representative from the ED participates in the prehospital PIPS program.
7.7 A designated emergency physician is available to the trauma director for PIPS issues that occur in the ED.
7.8 There is emergency physician participation with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee (dealing with systems issues).
7.9 The emergency medicine representative or designee to the multidisciplinary peer review committee attends a minimum of 50% of these meetings.
7.10 There are emergency physicians who have successfully completed the ATLS course.
7.11 Physicians who are not board-certified in emergency medicine who work in the ED are current in ATLS.
8. Clinical Functions: Neurosurgery
8.1 There is a trauma director-approved plan that determines which types and severity of neurologic injury patients should remain at the facility when no neurosurgical coverage is present.
8.2 There is a performance improvement program that convincingly demonstrates appropriate care in the facility that treats neurotrauma patients.
8.3 There are transfer agreements with appropriate Level I and II centers.
9. Clinical Functions: Orthopedic Surgery
9.1 Operating rooms are promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization and compartment decompression.
9.2 There is an orthopedic surgeon who is identified as the liaison to the trauma program.
9.3 The PIPS process reviews the appropriateness of the decision to transfer or retain major orthopedic trauma.
9.4 The orthopedic surgeon is on call and promptly available 24 hours a day.
9.5 The orthopedic service participates actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.
9.6 The orthopedic trauma liaison or representative attends a minimum of 50% of the multidisciplinary peer review meetings.
9.7 The orthopedic surgeon has privileges in general orthopedic surgery.
10. Collaborative Clinical Services
Anesthesia
10.1 Anesthesia services are promptly available for emergency operations.
10.2 Anesthesia services are promptly available for airway problems.
10.3 There is an anesthesiologist liaison designated to the trauma program.



10.4 The availability of the anesthesia services and the absence of delays in airway control or operations are documented in the hospital PIPS process.
10.5 Anesthesia services are available 24 hours a day and present for all operations.
10.6 In trauma centers without in-house anesthesia services, protocols are in place to ensure the timely arrival at the bedside of the anesthesia provider.
10.7 In a center without anesthesia services, there is documentation of the presence of physicians skilled in emergency airway management.
10.8 Availability of anesthesia services and the absence of delays in airway control or operations are documented by the hospital PIPS process.
10.9 The anesthesia liaison is identified.
10.10 The anesthesia representative participates in the trauma PIPS program.
10.11 The anesthesia representative or designee to the trauma program attends at least 50% of the multidisciplinary peer review meetings.
Operating Room
10.12 The operating room is adequately staffed and readily available.
10.13 The PIPS program evaluates the operating room availability and delays when an on-call team is used.
10.14 The operating room has the essential equipment.
Post anesthesia Care Unit (PACU)
10.15 The PACU has qualified nurses available 24 hours per day as needed during the patient's post anesthesia recovery phase.
10.16 The PACU is covered by a call team from home with documentation by the PIPS program that nurses are available and delays are not occurring.
10.17 The PACU has the necessary equipment to monitor and resuscitate patients.
10.18 The PIPS process ensures that the PACU has the necessary equipment to monitor and resuscitate patients.
Radiology
10.19 Radiologists are promptly available, in person or by teleradiology, when requested, for the interpretation of radiographs, performance of complex imaging studies, or interventional procedures.
10.20 Diagnostic information is communicated in a written form and in a timely manner.
10.21 Critical information is verbally communicated to the trauma team.
10.22 Final reports accurately reflect communications, including changes between preliminary and final interpretations.
10.23 Changes in interpretation are monitored by the PIPS program.
10.24 The trauma center has policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the radiology department.
10.25 Conventional radiography and CT are available 24 hours per day.
10.26 When the CT technologist responds from outside the hospital, the PIPS program documents response time.
Critical Care



10.27 The trauma center has a surgical director or codirector for the ICU who is responsible for setting policies and administration related to trauma ICU patients.
10.28 The trauma surgeon remains in charge of patients in the ICU.
10.29 When the patient is critically ill, there is a mechanism in place to provide prompt availability of ICU physician coverage 24 hours per day.
10.30 The surgical director or surgical codirector is a surgeon, is credentialed by the hospital to care for ICU patients, and participates in the PIPS program.
10.31 The trauma service retains responsibility for patients and coordinates all therapeutic decisions appropriate for its level.
10.32 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team.
10.33 Coverage of emergencies in the ICU leaves that ED with appropriate physician coverage.
10.34 The PIPS program reviews admissions and transfers to ensure appropriateness.
10.35 A qualified nurse is available 24 hours a day to provide care during the ICU phase.
10.36 The patient:nurse ratio does not exceed 2:1 for critically ill patients in the ICU.
10.37 The ICU has the necessary equipment to monitor and resuscitate patients.
10.38 There is intracranial pressure monitoring equipment in a center that admits neurotrauma patients.
Other Surgical Specialists
10.39 Has orthopedic surgery available.
Medical Consultants
10.40 Internal medicine specialists are available.
10.41 There is a respiratory therapist available and on call 24 hours per day.
10.42 Laboratory services are available 24 hours per day for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate.
10.43 The blood bank is capable of blood typing and cross-matching.
10.44 The blood bank has an adequate amount of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, or appropriate coagulation factors to meet the needs of injured patients.
10.45 The capability for coagulation studies, blood gases, and microbiology are present.
11. Rehabilitation
11.1 The hospital has physical therapy services.
11.2 The hospital has social services.
12. Trauma Registry
12.1 Trauma registry data are collected and analyzed.
12.2 The data are submitted to the National Trauma Data Bank.
12.3 The trauma center uses the registry to support the PIPS program.
12.4 The trauma registry has at least 80% of the trauma cases entered within 180 days of treatment.
12.5 The trauma program ensures that trauma registry confidentiality measures are in place.
12.6 There are strategies for monitoring data validity for the trauma registry.
13. Performance Improvement and Patient Safety (PIPS)
13.1 The trauma center demonstrates a clearly defined PIPS program for the trauma population.



13.2 The PIPS program is supported by a reliable method of data collection that consistently gathers valid and objective information necessary to identify opportunities for improvement.
13.3 The program is able to demonstrate that the trauma registry supports the PIPS process.
13.4 The process of analysis includes multidisciplinary review.
13.5 The process of analysis occurs at regular intervals to meet the needs of the program.
13.6 The results of analysis define corrective strategies.
13.7 The results of analysis and corrective strategies are documented.
13.8 The trauma program is empowered to address issues that involve multiple disciplines.
13.9 The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.
13.10 The trauma program has a medical director with the authority and administrative support to lead the program.
13.11 The trauma medical director has sufficient authority to set qualifications for the trauma service members.
13.12 The trauma director has the authority to recommend changes for the trauma panel based on performance review.
13.13 Identified problem trends undergo multidisciplinary peer review by the Trauma Peer Review Committee.
13.14 The trauma center is able to separately identify the trauma patient population for review.
13.15 There is a process to address trauma program operational issues.
13.16 There is documentation reflecting the review of operational issues and, when appropriate, the analysis and proposed corrective actions.
13.17 The process identifies problems.
13.18 The process demonstrates problem resolution (loop closure).
13.19 There is a trauma multidisciplinary peer review committee with participation by the trauma medical director or designee and representatives from general surgery, orthopedic surgery, neurosurgery, emergency medicine, and anesthesia.
13.20 The attendance by the trauma medical director and the specialty representatives is greater than 50%.
13.21 The core general surgeon attendance at the trauma peer review committee is greater than 50%.
13.22 In circumstances when attendance is not mandated (noncore members), the trauma medical director ensures dissemination of information from the trauma peer review committee.
13.23 The trauma medical director documents the dissemination of information from the trauma peer review committee.
13.24 Evidence of appropriate participation and acceptable attendance is documented in the PIPS process.
13.25 Deaths are systematically categorized as preventable, nonpreventable, or potentially preventable.
13.26 When a consistent problem or inappropriate variation is identified, corrective actions are taken and documented.
14. Outreach and Education
14.1 The trauma center is engaged in public and professional education.



14.2 The trauma center is involved in prevention activities, including public education activities.
14.3 The hospital provides a mechanism for trauma-related education for nurses involved in trauma care.
14.4 All general surgeons and emergency medical physicians on the trauma team have successfully completed the ATLS course at least once.
15. Prevention
15.1 The trauma center participates in injury prevention.
16. Disaster Planning and Management
16.1 The hospital meets the disaster-related requirements of the Joint Commission.
16.2 A trauma panel surgeon is a member of the hospital's disaster committee.
16.3 Hospital drills that test the individual hospital's disaster plan are conducted at least every six months.
16.4 The trauma center has a hospital disaster plan described in the hospital disaster manual.
17. Organ Procurement Activities
17.1 The trauma center has an established relationship with a recognized OPO.
17.2 There are written policies for triggering notification of the OPO.
17.3 The PIPS process reviews the organ donation rate.
17.4 There are written protocols for declaration of brain death.

Level IV Trauma Center

Designation Criteria for Level IV Trauma Center

Criteria for designation of Level IV trauma centers are based upon Resources for Optimal Care of the Injured Patient, COT/American College of Surgeons, 2006. Criteria to verify the services and systems are in place to ensure optimal care of the trauma patient are defined in that document. The following elements must be met for designation as a Level IV trauma center in Idaho.

Type I criteria must be in place at the time of the verification site visit to achieve verification. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of verification is issued. During the ensuing 12 months, if the trauma center successfully corrects the deficiencies, the period of verification will be extended to 3 years from the date of the initial verification visit.

If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital will not be verified.

Criteria Element	Type
1. Trauma Systems	
1.1 Meaningful involvement in state and regional trauma system planning, development, and operation is essential for all designated trauma centers and participating acute care facilities within a region.	I
1.2 The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants.	I
1.3 They must function in a way that encourages trauma center-based standardization, integration, and PIPS out to the region while engaging in inclusive trauma system planning and development.	I
2. Description of Trauma Centers and Their Roles in a Trauma System	
2.1 This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care.	I
2.2 Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification.	I
2.3 For Level IV trauma centers, it is expected that the physician or midlevel provider will be in the ED on patient arrival for the highest level of activation, provided there is adequate notification from the prehospital providers. The maximum acceptable response time is 30 minutes, from patient arrival in the ED. The PIPS program must demonstrate that the provider's presence is in compliance at least 80% of the time.	I
2.4 Well-defined transfer plans are essential.	I
2.5 A level IV facility must have 24-hour emergency coverage by a physician or midlevel provider.	I
2.6 The ED at Level IV centers must be continuously available for resuscitation with coverage by a registered nurse and physician or midlevel provider,.	I



2.7 These providers must have successfully completed ATLS certification as part of their competencies in trauma.	II
2.8 A trauma medical director and trauma program manager knowledgeable and involved in trauma care must work together with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking.	II
2.9 The multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured.	I
2.10 A PIPS program must have audit filters to review and improve pediatric and adult patient care.	II
2.11 Collaborative treatment and transfer guidelines reflecting the Level IV facilities' capabilities must be developed and regularly reviewed, with input from higher-level trauma centers in the region.	II
2.12 Because of the greater need for collaboration with receiving trauma centers, the Level IV trauma center must also actively participate in regional and statewide trauma system meetings and committees that provide oversight.	I
2.13 The Level IV trauma center must also be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers.	II
2.14 The facility must participate in regional disaster management plans and exercises.	II
3. Prehospital Trauma Care	
3.1 The protocols that guide prehospital trauma care must be established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel.	II
3.2 When a trauma center is required to go on bypass or divert, the center must have a system to notify dispatch and EMS agencies. The center must do the following:	
a. Prearrange alternative destinations with transfer agreements in place	II
b. Notify other centers of divert or advisory status	
c. Maintain a divert log	
d. Subject all diverts and advisories to performance improvement procedures	
4. Interhospital Transfer	
4.1 A very important aspect of interhospital transfer is an effective PIPS program that includes evaluating transport activities. Perform a PIPS review of all transfers.	I
	II
5. Hospital Organization and the Trauma Program	
5.1 Documentation of administrative commitment is required from the governing body and the medical staff.	I
5.2 The criteria for a graded activation must be clearly defined by the trauma center, with the highest level of activation including the six required criteria listed in Table 1.	II



5.3 Other potential criteria for trauma team activation that have been determined by the trauma program to be included in various levels of trauma activation must be evaluated on an ongoing basis in the PIPS process to determine their positive predictive value in identifying patients who require the resources of the full trauma team.	II
5.4 In Level IV trauma centers the team must be fully assembled within 30 minutes of notification or patient arrival, whichever is shorter.	II
5.5 At a minimum, the six criteria listed in Table 1 to be included in the highest level of activation in all trauma centers.	II
5.6 Again, the six criteria listed in Table 1 must remain in the highest level of activation.	II

Table 1. Minimum Criteria for Full Trauma Team Activation	
<ul style="list-style-type: none"> Confirmed blood pressure less than 90 mm Hg at any time in adults and age-specific hypotension in children; 	
<ul style="list-style-type: none"> Gunshot wounds to the neck, chest, or abdomen or extremities proximal to the elbow/knee; 	
<ul style="list-style-type: none"> Glasgow Coma Scale score less than 9 with mechanism attributed to trauma; 	
<ul style="list-style-type: none"> Transfer patients from other hospitals receiving blood to maintain vital signs; 	
<ul style="list-style-type: none"> Intubated patients transferred from the scene, OR 	
<ul style="list-style-type: none"> Patients who have respiratory compromise or are in need of emergent airway 	
<ul style="list-style-type: none"> Included intubated patients who are transferred from another facility with ongoing respiratory compromise (does not include patients intubated at another facility who are now stable from a respiratory standpoint) 	
<ul style="list-style-type: none"> Emergency physician's discretion 	

6. Clinical Functions: General Surgery	
6.1 For Level IV trauma centers with surgical capabilities, the maximum acceptable response time is 30 minutes. Response time will be tracked from patient arrival rather than from notification or activation. An 80% attendance threshold must be met for the highest-level activations.	I
7. Collaborative Clinical Services	
7.1 Conventional radiology services (non-CT) must be available in all trauma centers 24 hours per day.	I
7.2 The PIPS program must document that timely and appropriate ICU care and coverage are being provided when available.	II
7.3 Laboratory services must be available 24 hours per day for the standard analyses of blood, urine, and other body fluids, including microsampling when appropriate.	I
7.4 The blood bank must be capable of blood typing and cross-matching.	I
7.5 Must have a transfusion protocol developed collaboratively between the trauma service and the blood bank.	I
7.6 Non-physician providers who participate in the initial evaluation of trauma patients must demonstrate current verification as an ATLS provider.	II

7.7 The trauma program must also demonstrate appropriate orientation, credentialing process, and skill maintenance for advanced practitioners as witnessed by an annual review by the trauma medical director.	II
8. Rural Trauma Care	
8.1 Transfer guidelines and agreements between facilities are crucial and must be developed after evaluating the capabilities of rural hospitals and medicine transport agencies.	II
8.2 All transfers must be evaluated as part of the receiving trauma center's PIPS process and feedback should be provided to the transferring center	II
8.3 Issues that must be reviewed will revolve predominately around (1) system and process issues such as documentation and communication; (2) clinical care, including identification and treatment of immediate life-threatening injuries; and (3) transfer decisions.	I
8.4 The best possible care for patients must be achieved with a cooperative and inclusive program that clearly defines the role of each facility within the system.	II
9. Guidelines for the Operation of Burn Centers	
9.1 Trauma centers that refer burn patients to a designated burn center must have in place written transfer agreements with the referral burn center.	II
10. Trauma Registry	
10.1 Trauma registry data must be collected and analyzed by every trauma center. Data must be collected by State of Idaho TSE trauma registry.	II
10.2 All trauma centers must use a risk stratified benchmarking system to measure performance and outcomes.	II
11. Performance Improvement and Patient Safety (PIPS)	
11.1 Criteria for all levels of trauma team activation (TTA) must be defined and reviewed annually. See table 1 for minimal acceptable criteria.	II
11.2 All Trauma Team Activations must be categorized by the level of response and quantified by number and percentage, as shown in table 1.	II
11.3 In level IV trauma centers with surgical capability Trauma surgeon response time to other levels of TTA, and for back-up call response, should be determined and monitored. Variances should be documented and reviewed for reason for delay, opportunities for improvement, and corrective actions.	II
11.4 In level IV Centers with ICU capability, transfers to a higher level of care within the institution must be routinely monitored, and cases identified must be reviewed to determine the rationale for transfer, adverse outcomes, and opportunities for improvement.	II
11.5 The trauma center must demonstrate that all trauma patients can be identified for review.	II
11.6 The trauma PIPS program must be supported by a registry and a reliable method of concurrent data collection that consistently obtains information necessary to identify opportunities for improvement.	II
11.7 All trauma centers must use a risk stratified benchmarking system to measure performance and outcomes.	II
11.8 To achieve this goal, a trauma program must use clinical practice guidelines, protocols, and algorithms derived from evidence-based validated resources.	II



11.9 All process and outcome measures must be documented within the trauma PIPS program's written plan and reviewed and updated at least annually.	II
11.10 Once an event is identified, the trauma PIPS program must be able to verify and validate that event.	II
12. Outreach and Education	
12.1 All verified trauma centers, however, must engage in public and professional education.	II
12.2 The successful completion of the ATLS course, at least once, is required in all levels of trauma centers for all general surgeons, emergency medicine physicians, and midlevel providers on the trauma team.	II
13. Prevention	
13.1 Each trauma center must have someone in a leadership position that has injury prevention as part of his or her job description.	II
13.2 Trauma centers must have an organized and effective approach to injury prevention and must prioritize those efforts based on local trauma registry and epidemiologic data.	II
13.3 Universal screening for alcohol use must be performed for all adolescent and adult injured patients and must be documented. Screening and brief intervention for alcohol use is required for all trauma centers.	II
14. Disaster Planning and Management	
14.1 All trauma centers must have a hospital disaster plan described in the hospital's policy and procedure manual or equivalent.	II
15. Organ Procurement Activities	
15.1 It is essential that each trauma center have written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death.	II

Type I criteria must be in place at the time of the verification site visit to achieve verification. Type II criteria are also required but are less critical. If one to three Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of verification is issued. During the ensuing 12 months, if the trauma center successfully corrects the deficiencies, the period of verification will be extended to 3 years from the date of the initial verification visit.

If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital is not verified.

Level V Trauma Center

Designation Criteria for Level V Trauma Center

The following elements must be met for designation as a Level V trauma center in Idaho.

E- Essential element for designation.

D- Desired element for designation.

Criteria Element	Type
1. Center Mission	
1.1 Center is a health care facility (as defined in section 10 of the TSE Rules) with the commitment, medical staff, personnel, and training necessary to provide initial care and stabilization to the trauma patient.	E
1.2 Center provides initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and to assure maximal stabilization prior to referral to an appropriate higher level of care.	E
1.3 The decision to transfer rests with the attending provider.	E
1.4 Center works collaboratively with state agencies and other trauma centers to develop transfer protocols and a well-defined transfer sequence.	E
1.5 Center will participate in the Regional TSE Committee.	E
2. Center Organization	
Trauma Program/Director	
2.1 The trauma program is established and recognized by the medical staff and administration.	E
2.2 The director is trained, experienced and committed to the care of the trauma patient.	E
2.3 The director is responsible for developing and directing the quality improvement program.	E
2.4 The director has the overall accountability for all trauma care and exercises administrative authority for the trauma program.	E
2.5 The director is given administrative support for implementation of requirements as outlined in this document.	E
2.6 The director maintains personal involvement in patient care, staff education and professional organizations and the trauma system at the community and state level.	E
2.7 The program director of the trauma team is ATLS certified and current.	E
Trauma Team	
2.8 Center policy and procedures describe the role of all personnel on the trauma team.	E
2.9 The trauma team is directed by a qualified director.	D
2.10 The trauma team consists of:	
a. Mid Level Practitioners	D



b. RN	E
Trauma Team Qualifications	
2.12 Where mid-level RNP or PA-C providers staff the emergency department, there must be documentation of training and knowledge of care for the trauma patient.	E
2.13 Trauma team physicians and mid-level providers are credentialed by the medical staff and governing board.	E
2.14 Trauma team physicians which are not board certified or eligible are reviewed by the medical director of trauma service and credentialed by the medical staff and governing board.	E
2.15 Trauma team members participate in multi-disciplinary trauma committee and the quality improvement process.	E
2.16 There are written guidelines at the local level to determine which types of patients are admitted and which are appropriately transferred.	E
2.17 Trauma physicians must have documentation of training and knowledge of care for the trauma patient	E
Trauma Program Manager	
2.18 The center has designated in writing a trauma program manager. The trauma program manager shows evidence of educational preparation and clinical experience of injured patients.	E
2.19 There is evidence that the trauma program manager works with the trauma director to address the multidisciplinary needs of the trauma program.	E
2.20 The trauma program manager is responsible for the use of trauma registry data for quality improvement and trauma education.	E
2.21 The trauma program manager is liaison with local EMS and accepting centers.	E
3. Clinical Components	
3.1 There is a health care provider(s) (MD, DO, FNP, PA) during hours of operation. It is expected that the health care provider will be in the center within 30 minutes of patient arrival.	E
3.2 There is a call list of specialists (when available) who are promptly available from inside or outside of the center. The list is posted in the center.	E
3.3 Policy and procedures exist to notify the patient's primary care physician of the patient's condition at an appropriate time.	E
4. Center Standards	
4.1 The center is staffed to assure immediate and appropriate care to trauma patients during hours of operation.	E
4.2 The provider is available during hours of operation and is immediately available and capable of performing initial resuscitation and other procedures not requiring general anesthesia.	E
4.3 The center has established standards to ensure immediate and appropriate care of the adult and pediatric trauma patient.	E
4.4 The program director participates in the Trauma Committee and the trauma QI process attending at least 50% of meetings.	E



4.5 There is RN staffing in the center during hours of operation at levels necessary to meet the needs of the trauma patient.	E
4.6 There is evidence of nursing participation in the trauma QI program.	E
5. Clinical Support Services	
5.5 There is written policy to delineate the availability of CT services to the trauma patient.	E
Transfer Protocols	
5.10 There are transfer protocols in place with Level I, Level II, and Level III centers as well as specialty referral centers, i.e. burn, pediatrics, and rehabilitation.	E
5.11 There is a feedback loop with Level I, Level II, and Level III centers to facilitate a good understanding of patient outcome.	E
5.12 There is evidence that all centers collaborate to develop guidelines indicating which patients are considered for transfer and procedures to ensure expedient and safe transfer of the trauma patient.	E
5.13 There is a provision for feedback to the referring center.	E
5.14 Trauma services are provided regardless of ability to pay.	E
5.15 Pediatric patients needing tertiary pediatric care are transferred according to written guidelines.	E
Performance Improvement (PI)	
5.16 The center participates in the trauma registry	E
5.17 The center participates in the statewide evaluation process, education and coordination activities.	E
5.18 There is evidence that the center develops and supports public education and awareness.	E
5.19 There is evidence of a functioning PI process in the center that:	
b. Has clearly stated goals and objectives.	E
c. Develops standards of care.	E
d. Has a process to credential trauma providers.	D
e. Has explicit quality indicators and filters.	E
f. Has a peer review process including pre-hospital providers.	E
g. Has a method for comparing patient outcomes with computed survival probability.	E
h. Autopsy information on all trauma deaths.	D
5.20 The center participates in the statewide quality review process.	E

Level I & II Pediatric Trauma Center

Designation Criteria for Level I and II Pediatric Trauma Center

Criteria for designation of Level I & II pediatric trauma centers are based upon *Resources for Optimal Care of the Injured Patient, COT/American College of Surgeons, 2006*. Criteria to verify the services and systems are in place to ensure optimal care of the trauma patient are defined in that document. The following elements must be met for designation as a Level I or II pediatric trauma center in Idaho.

Criteria Element	Level
1.1 Pediatric trauma centers meet the same resource requirements as adult trauma centers in addition to pediatric resource requirements.	I, II
1.2 A Level I pediatric trauma center annually admits 200 or more injured children younger than 15 years.	I
1.3 A Level II pediatric trauma center annually admits 100 or more injured children younger than 15 years.	II
1.4 A pediatric trauma center has a pediatric trauma program manager or coordinator.	I, II
1.5 A pediatric trauma center has a pediatric trauma registrar.	I, II
1.6 The pediatric trauma program manager or coordinator is dedicated to the pediatric trauma service.	I
1.7 A pediatric trauma center has a pediatric trauma PIPS program.	I, II
1.8 A pediatric trauma center has all of the following programs: pediatric rehabilitation; child life and family support programs; pediatric social work and child protective services; pediatric injury prevention and community outreach programs; and pediatric trauma education programs.	I, II
1.9 A pediatric trauma center has identifiable pediatric trauma research.	I
1.10 A Level I pediatric trauma center has at least 2 surgeons, board-certified or board-eligible in pediatric surgery by the American Board of Surgery.	I
1.11 A Level I pediatric trauma center has at least 1 board-certified or board-eligible orthopedic surgeon who has had pediatric fellowship training.	I
1.12 A Level I pediatric trauma center has at least 1 board-certified or board-eligible neurosurgeon who has had pediatric fellowship training.	I
1.13 A Level I pediatric trauma center has at least 1 additional board-certified or board-eligible orthopedic surgeon with demonstrated skills and interest in the care of pediatric trauma patients.	I
1.14 A Level I pediatric trauma center has at least 1 additional board-certified or board-eligible neurosurgeon with demonstrated skills and interest in the care of pediatric trauma patients.	I
1.15 A Level I pediatric trauma center has at least 2 physicians who are board-certified or board-eligible in pediatric critical care medicine (pediatric or surgical).	I
1.16 A Level I pediatric trauma center has at least 2 physicians board-certified or board-eligible in pediatric emergency medicine.	I
1.17 Individuals who provide pediatric care in the pediatric ICU are credentialed by the hospital to provide pediatric trauma care in their respective trauma areas.	I, II



1.18 Individuals who provide pediatric care in the pediatric area of the ED are credentialed by the hospital to provide pediatric care in the ED.	I, II
1.19 A Level II pediatric trauma center has at least 1 surgeon who is board-certified or board-eligible in pediatric surgery.	II
1.20 A Level II pediatric trauma center has at least 1 additional board-certified or board-eligible orthopedic surgeon with interests and skills in pediatric surgery.	II
1.21 A Level II pediatric trauma center has at least 1 board-certified or board-eligible neurosurgeon with interests and skills in pediatric surgery.	II
1.22 The pediatric trauma medical director is board-certified or board-eligible in general surgery.	I, II
1.23 The pediatric trauma medical director is board-certified or board-eligible in pediatric surgery.	I
1.24 There are non-pediatric-trained surgeons serving on the pediatric panel with proper qualifications:	I, II
a. credentialed by the hospital to provide pediatric trauma care;	
b. members of the adult trauma panel;	
c. the pediatric trauma medical director has agreed to their having sufficient training and experience in pediatric trauma care; and	
d. their performance has been reviewed by the pediatric PIPS program.	
1.25 Trauma surgeon attendance in the ED for the highest level of activations is documented to be greater than 80%.	I, II
1.26 There is a mechanism for documenting surgeon presence in the operating room.	I, II
1.27 The program offers specialty-specific pediatric education for the specialists.	I, II
1.28 There is a pediatric trauma service led by the trauma medical director.	I, II
1.29 All hospitals seeking verification as an adult and pediatric trauma center meet criteria for the verification level sought in each type of center.	I, II
1.30 Trauma surgeons in adult trauma centers that admit 100 or more injured children annually are credentialed for pediatric trauma care by the hospital's credentialing body.	I, II
1.31 The adult trauma center that admits 100 or more injured children annually has all of the following: a pediatric emergency department area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS program.	I, II
1.32 The adult trauma center that admits fewer than 100 injured children annually reviews care of injured children through the PIPS program.	I, II
1.33 There is a multidisciplinary peer review committee with participation by the trauma medical director or designee and representatives from pediatric/general surgery, orthopedic surgery, neurosurgery, emergency medicine, critical care medicine, and anesthesia that reviews selected deaths, complications, and sentinel events to identify issues and appropriate responses.	I, II
1.34 Attendance by the required representatives to at least 50% of the multidisciplinary peer review meetings is documented.	I, II
1.35 The pediatric trauma medical director and the liaisons from neurosurgery, orthopedic surgery, emergency medicine, and critical care medicine have adequate pediatric trauma CME.	I, II





The logo for the Idaho Department of Health and Welfare, featuring the word "IDAHO" in a large, bold, serif font. The letter "A" is stylized with a diagonal slash. The logo is positioned in the upper left corner of the slide, with a background image of a mountain range and a lake.

IDAHO

Department of
Health and Welfare

**Idaho Department
of Health & Welfare**

Budget Presentation

**Richard Armstrong
Director**

February 12, 2015



IDAHO DEPARTMENT OF
HEALTH & WELFARE



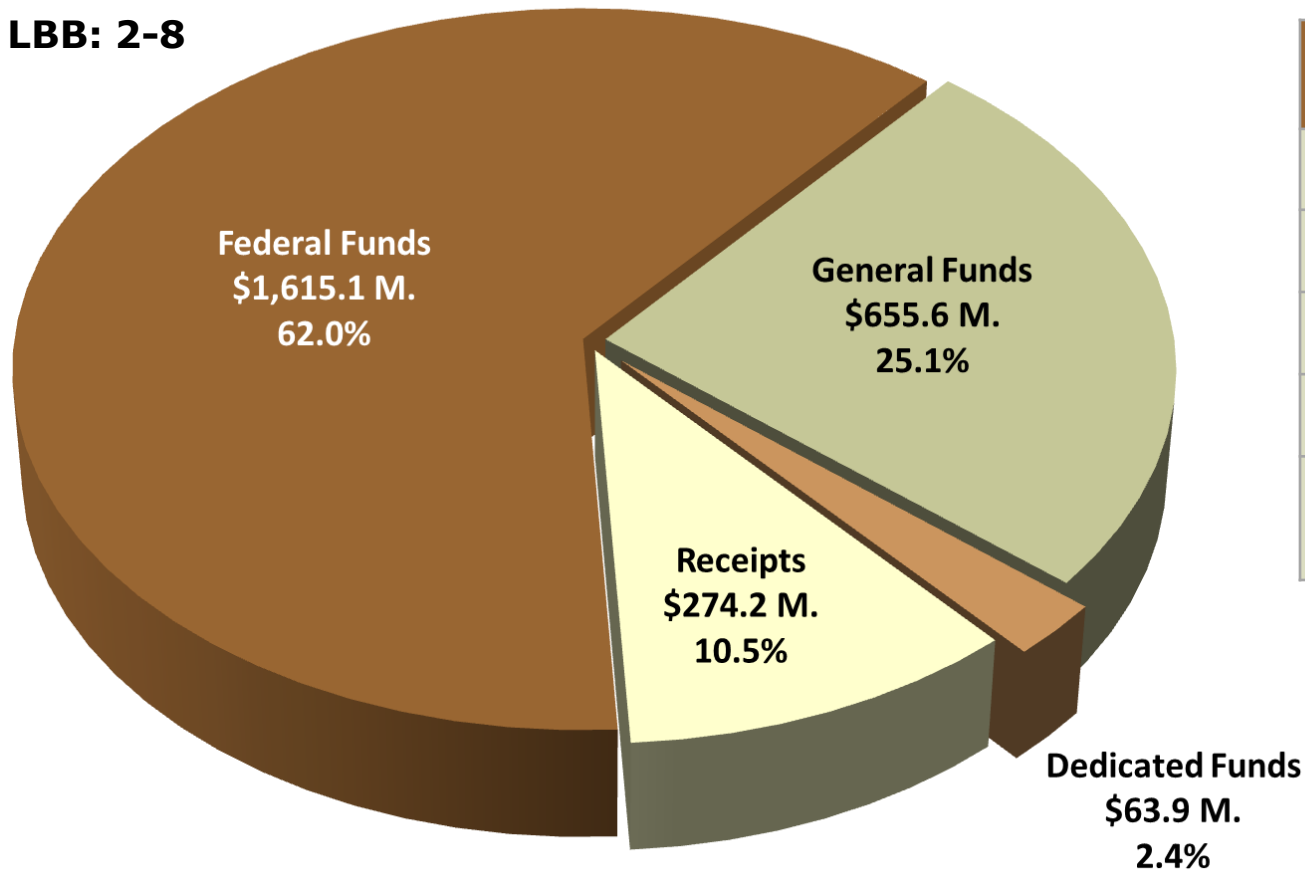
Today's Presentation

- 1. State Healthcare Innovation Plan (SHIP) to transform Idaho's healthcare system**
- 2. Budget Recommendations**
- 3. Employee CEC**
- 4. The unique and vital role DHW's eligibility system provides for Idaho's insurance exchange**
- 5. Economic recovery continues, but high workloads remain**



DHW SFY 2016 Recommendation by Funding Source

LBB: 2-8



Total: \$2.61 B.

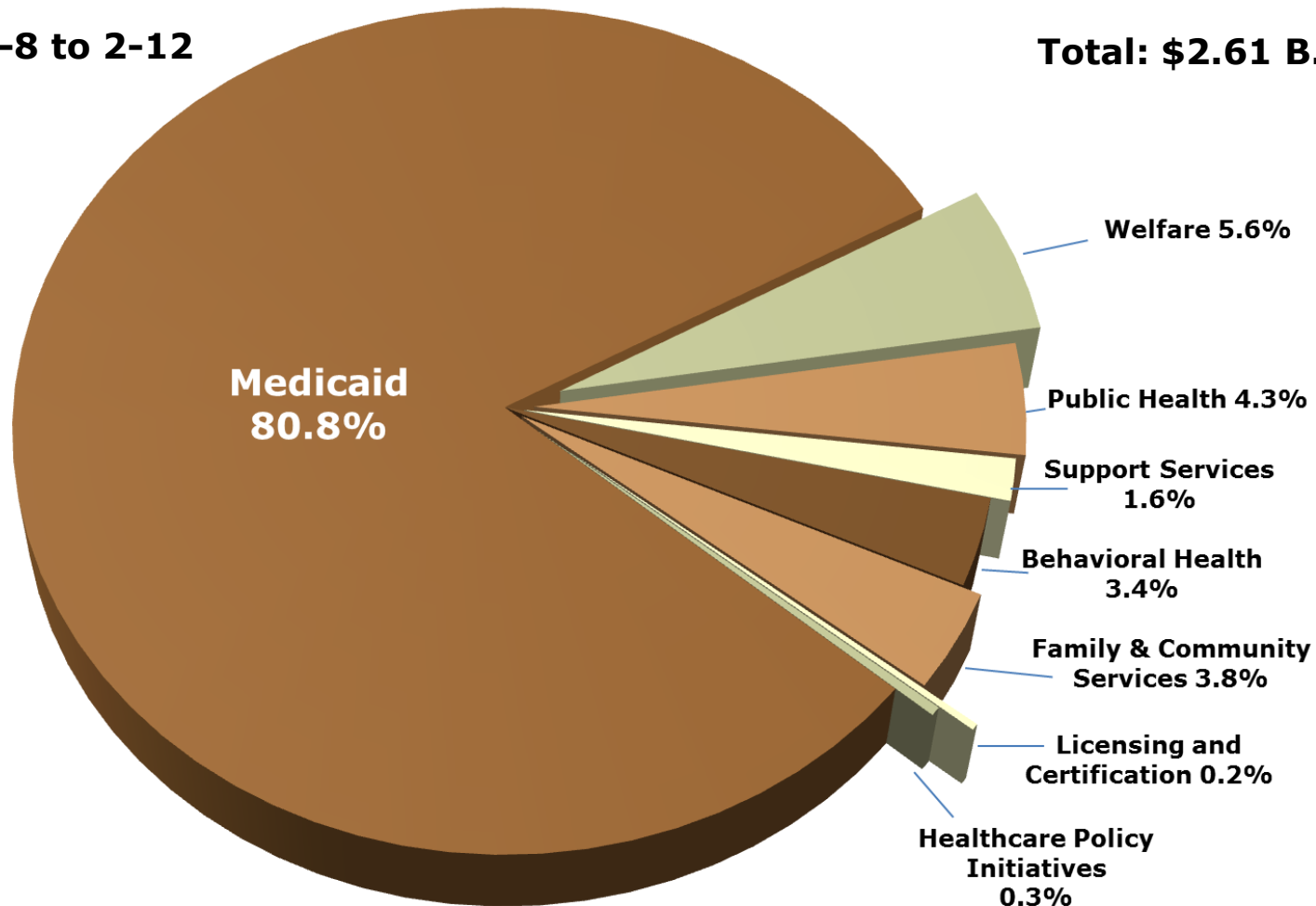
Increase from SFY 2015	
General	2.8%
Dedicated	-3.6%
Receipts	31.8%
Federal	-1.1%
Total	3.3%



DHW SFY 2016 Recommendation by Program

LBB: 2-8 to 2-12

Total: \$2.61 B.

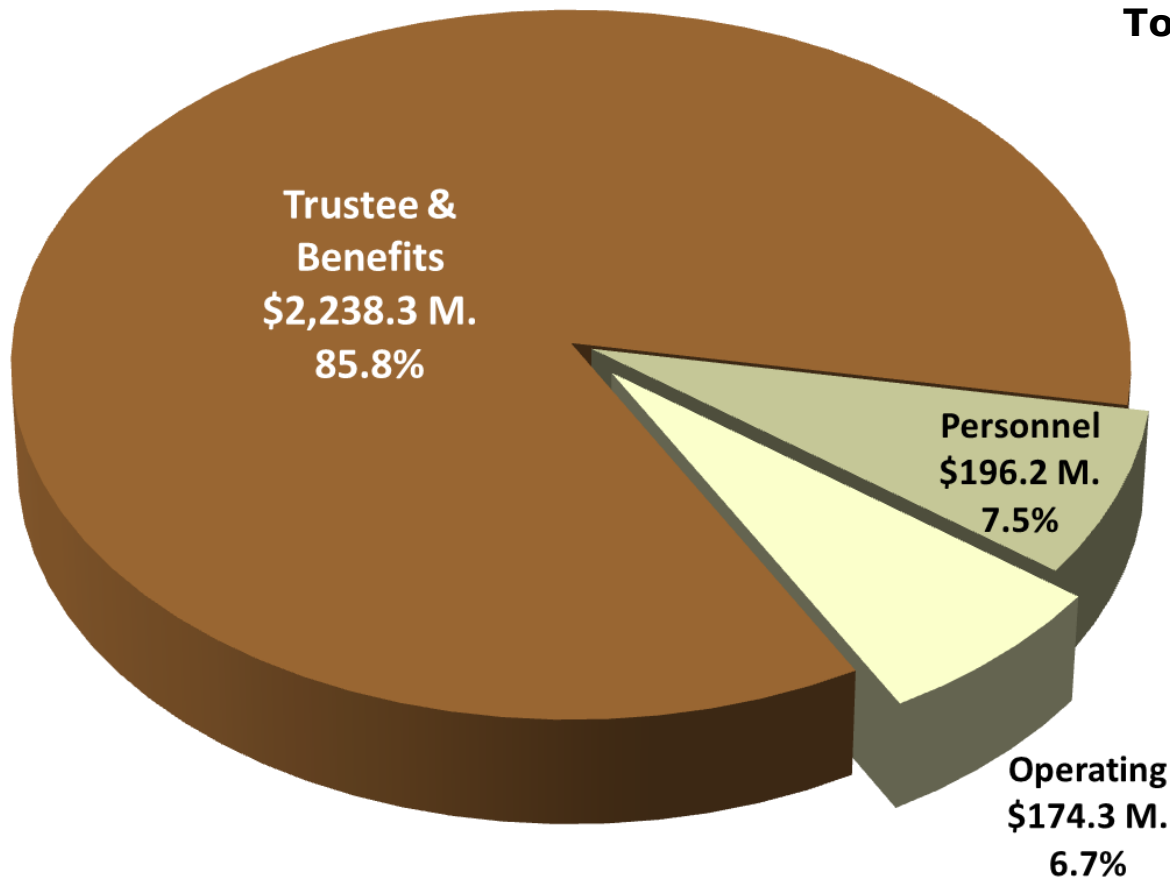




DHW SFY 2016 Recommendation by Object

FTP: 2,870

Total: \$2.61 B.





The Evolution of Idaho's Healthcare System

Since 2007, key pieces of legislation and executive orders began a progression towards high quality, patient-centered medical care.

2007-2010

Gov. Otter forms Medical Home Collaborative to develop Patient Centered Medical Home (PCMH) model.

2011

Legislature directs Medicaid to transition to managed care solutions; improve patient care coordination.

2012-2013

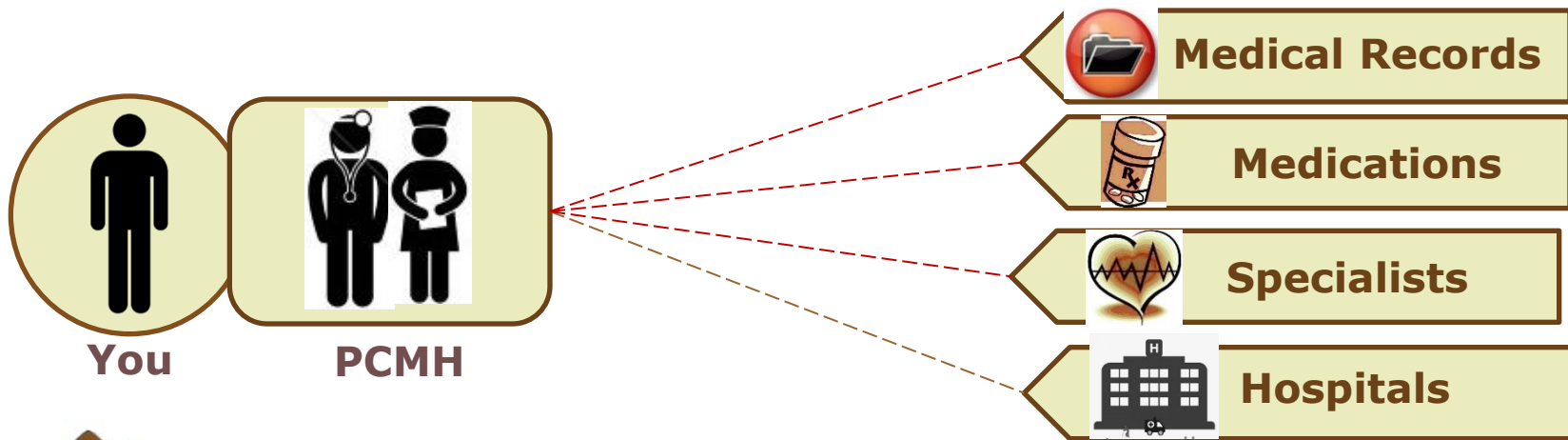
Idaho Healthcare Coalition plans reform; State pilots PCMH model. Idaho opts for state insurance exchange to improve healthcare coverage.

Idaho SHIP

- State receives \$39.6 M. grant to reform healthcare system.
- SHIP relies on PCMH as foundation.
- Model holds patient and healthcare delivery system accountable for improved outcomes.



SHIP: Patient Centered Medical Homes (PCMH)



Why PCMH?



People with Chronic
Conditions Account for:

National
Healthcare Dollars



Medicare
Spending



- Adults with primary care physician have 33% lower costs of care
- Less duplication or unnecessary tests
- Less likely to delay care or seek ER care
- Fewer hospital admissions
- More appropriate use of prescriptions



Health Home Impacts on Medicaid Hospital Care

Medicaid Pilot Jan. – June 2014

- **3,740 Medicaid adults with chronic illnesses assigned to health homes**
- **Pilot reduced average monthly member costs by over 20%**
- **Preliminary estimate of return on investment : 10/1**

Adult Health Home Impact on Hospital Care					
2014 vs. 2013 (Jan. to June)					
	Admits/1,000 Members	-25.8%		Readmissions	-41%
	Patient Days/1,000 Admits	-21.1%		ER/1,000 Members	-23.7%
	Avg. Length of Stay	6.3%*		ER Net Payment	-2.6%
	Net Pay/Admit	33.1%*			

**Increases were expected due to avoiding unnecessary short stays and less complex procedures being removed.*



SFY 2016 SHIP Recommendation

FTP	General Funds	Federal Funds	Total
8 FTP, including 7 limited service positions	\$ 0	\$8,855,100	\$8,855,100

- **SHIP grant is for \$39.6 M. in federal funds over four years**
- **Administered by the Healthcare Policy Initiative program**
- **SFY 2016 = \$8.9 M.:**
 - ✓ **7 new, limited service FTP; 1 permanent FTP**
 - ✓ **Targeting 55 primary care practices to PCMH**
 - ✓ **Connect Electronic Health Records to Idaho Health Data Exchange**
 - ✓ **Develop Regional Collaboratives with Health Districts to support local, coordinated care**



Jeff D Plaintiff Attorney Fees

LBB	FTP	General	Federal	Total
2-51 #2	0	\$615,000	\$0	\$615,000

- **Three plaintiff attorneys**
- **Final stages of settlement agreement; nine months of planning and four years to implement when it is approved**
- **Fees are subject to negotiation**



Medicaid: Hepatitis C Drugs

LBB	FTP	General	Federal	Total
2-42 #3	0	\$1,885,000	\$4,615,000	\$6,500,000

- **Can actually cure specific types of hepatitis-c infections.**
- **Costs at least \$100,000 per patient for a treatment that includes Solvaldi; most patients cost more.**
- **Requires prior-authorization.**
- **Medicaid is required to pay for FDA approved drugs when they are medically necessary.**
- **Similar drug treatments coming on market may replace this high-priced treatment in the future.**



Access to Recovery Grant IV

LBB	FTP	General	Federal	Total
2-80 #5	2	\$0	\$796,700	\$796,700

- **Awarded October 2014; \$7.87 million over three years**
- **Targeted for veterans in the criminal justice system, families involved with child protection and homeless population**
- **Expected to serve over 3,400 Idahoans with substance use disorders**



Second Community Crisis Center

LBB	FTP	General	Federal	Total
2-52 #1	0	\$1,520,000	\$200,000	\$1,720,000

- **The Behavioral Health Crisis Center of East Idaho opened Dec. 12**
- **Crisis centers provide a safe, voluntary, effective and efficient alternative to ERs and jails**
- **Hospitals, counties, cities and the state should all realize savings**
- **Contract with Bonneville County requires county/partners to develop a plan to cover 50% of operating expenses within two years**



Food Stamp Multi-day Issuance

LBB	FTP	General	Federal	Total
2-87 #2	3	\$39,500	\$628,800	\$668,300

- **Changes Food Stamp distribution from 1 day to 10 days**
- **Includes \$589,400 in one-time programming costs funded by high-performance bonus**
- **2016 recommendation is for six months**
- **Total annualization for SFY 2017 = \$211,400 (50% state/50% federal funds)**



Health Facility Surveyors

LBB	FTP	General	Federal	Total
2-97 #3	4	\$72,500	\$274,700	\$347,200

- **Current backlog of 11 facilities awaiting initial licensing, 275 overdue surveys, 135 complaints requiring investigation**
- **3,166 surveys due during 2015, along with complaint investigations/follow-up**
- **Takes 6 to 9 months to train and certify surveyors**



Community Hospitalization Rate Increase

LBB	FTP	General	Federal	Total
2-62 #4	0	\$279,000	\$0	\$279,000

- **10 private psych hospitals**
- **Treat patients committed to the state until space is available at a state hospital**
- **Hospitals seeking rate increase; agreed to short-term contract extension for interim**



Adoption Caseload Growth

LBB	FTP	General	Federal	Total
2-16 #5	0	\$456,200	\$776,700	\$1,232,900

- **Adoptions are the best, permanent solution for foster children who cannot safely reunite with their families**
- **Subsidies are extremely important to pay for special needs of children who have suffered abuse and neglect**
- **Costs are increasing because:**
 1. **Successful adoptions are increasing, with more children in adoption situation**
 2. **Federal funding support has declined**



Laboratory Staff Pay Increase for Retention

LBB	FTP	General	Federal	Total
2-70 #6	0	\$111,200	\$39,700	\$150,900

- **19% turnover; pay is the primary reason**
- **Idaho lab workers average 23% less than surrounding states and private sector**
- **Majority of increase for mid-level scientists**



Cover TRICARE Immunizations

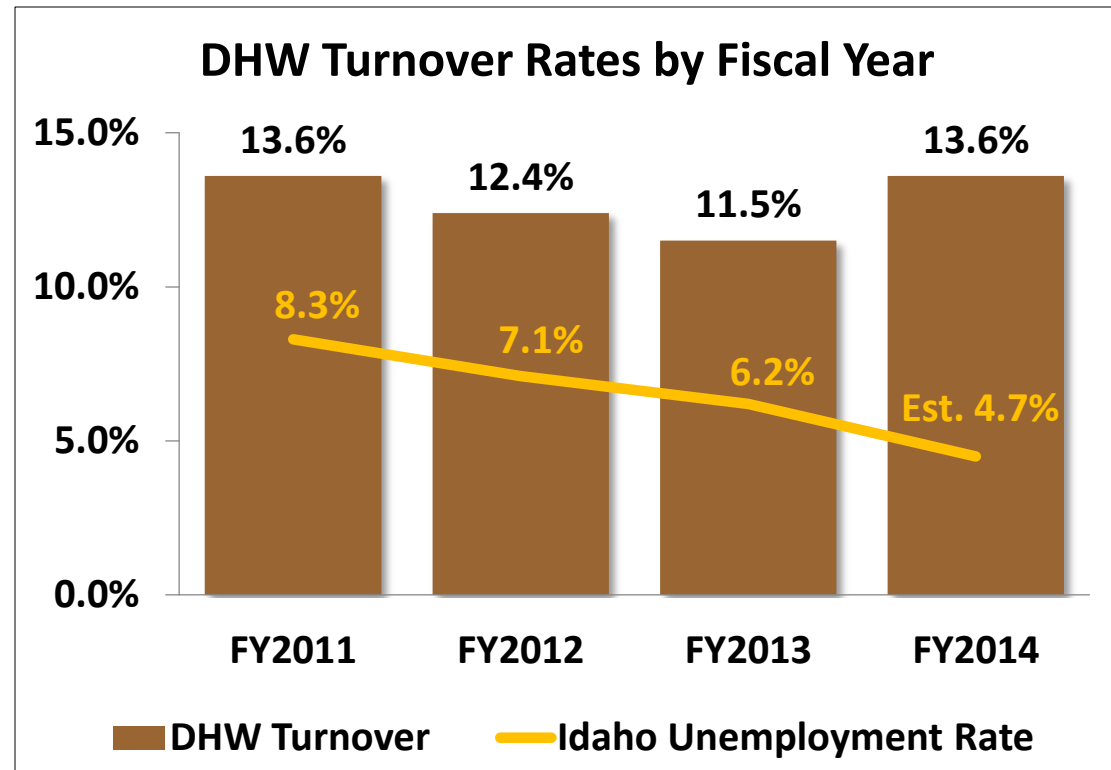
LBB	FTP	General	Federal	Total
2-70 #8	0	\$596,000	\$0	\$596,000

- **Federal insurer refuses to pay its share of Idaho's vaccine assessment**
- **Impacts military families**
- **A number of states are involved in similar negotiations**



Low Pay is Driving Workforce Turnover

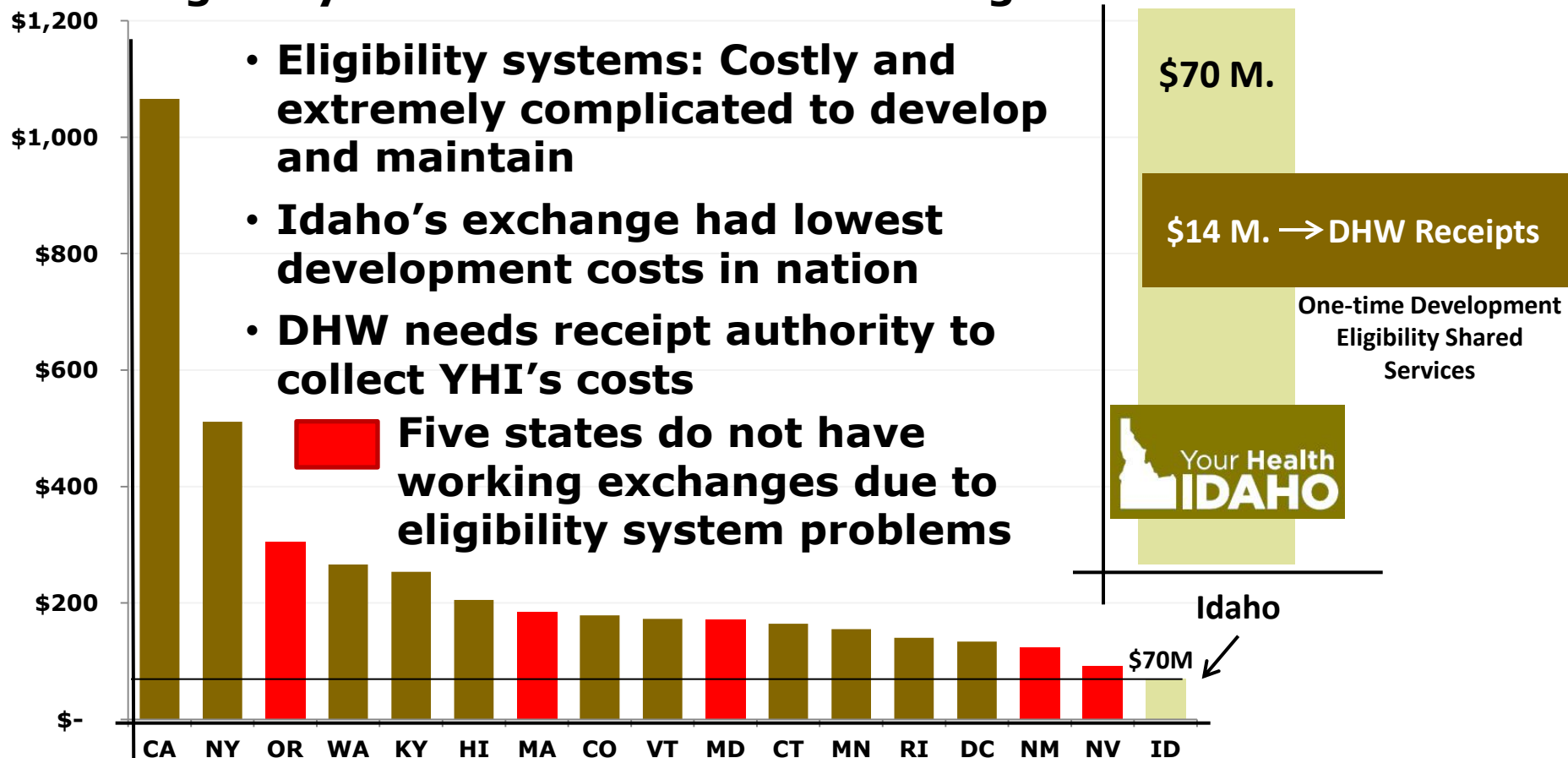
- **SFY 2014 DHW voluntary turnover rate: 13.6%**
- **Pay identified as the main or contributing factor: 54%**
- **Avg. pay increase in the private sector: 38%**
- **30% of turnover had < 2 years of service**
- **Recovering economy = Increased job opportunities and higher compensation that state agencies must compete against**





Idaho Shares Eligibility Services with Exchange

Eligibility Service Costs for 17 Exchanges



**Oregon has reverted to the federal exchange; Massachusetts, Maryland, New Mexico and Nevada do not have working state exchanges due to eligibility system issues.*



YHI Shared Services

	FTP	SFY 2015	SFY 2016	Total
Development Costs		\$9,230,000	\$4,970,000	\$14,200,000
Ongoing Operations	15	\$2,500,200		

- **No state general funds are involved; all activities are cost-allocated to YHI**
- **Shared eligibility minimized state risk and maximized functionality by using proven technology**
- **Share services includes rules engine, online application, case management system, connectivity to Federal Data Hub, integrated noticing system**



Shared Services Impact on YHI Performance

- **Transition from federal marketplace was delayed six weeks, from Oct. 1 to Nov. 15.**
- **Despite this delay, DHW has authorized tax credits for 94,861 people.**
- **Shortened enrollment timeframe caused consumer bottlenecks and call center wait times, but problems were addressed and remedied.**
- **Idaho was the only state to successfully transition from federal marketplace to state based exchange in 2014.**





Shared Services Data Mining

- Since open enrollment, almost 17,000 people requested health coverage assistance, but earned less than 100% of poverty and were not eligible for Medicaid or a tax credit, remaining uninsured.
- Food Stamp data identifies an additional 36,000 adults with incomes below 100% of poverty who are not receiving Medicaid or a tax credit.

0 -100% Federal Poverty Level

100% - 400% Federal Poverty Level

Gap Adults

- No tax credits
- Not Medicaid eligible

17,000 Applied

36,000 Food Stamp Data

53,000 Identified <100% FPL

**Private Insurance/Exchange
Eligible for Tax Credits**

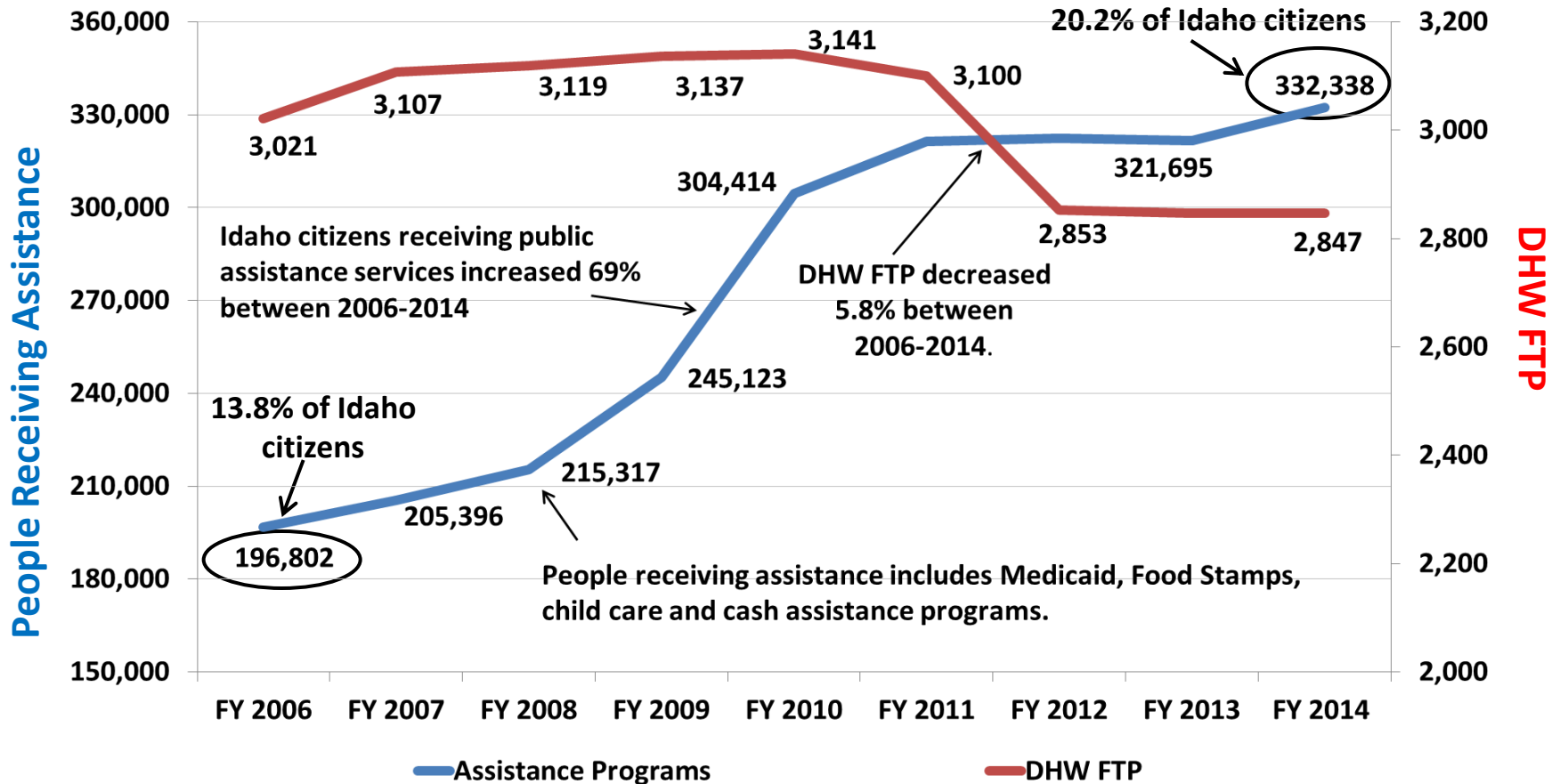
**84,000 Idaho citizens
were eligible for tax credit**

Income < \$11,670 / one adult

Income between \$11,670 and \$46,680 receives tax credit

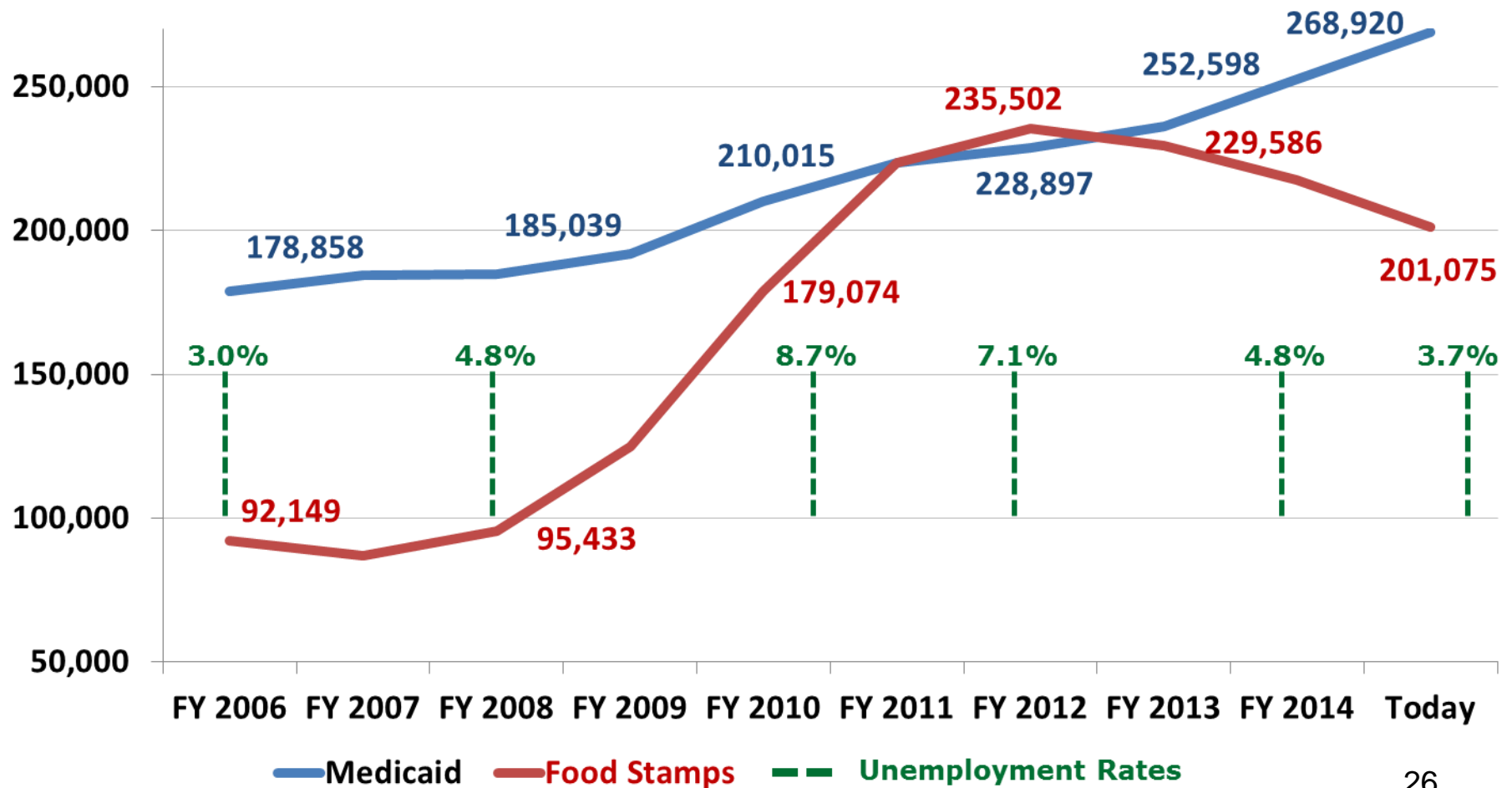


High Demands for Assistance Continues





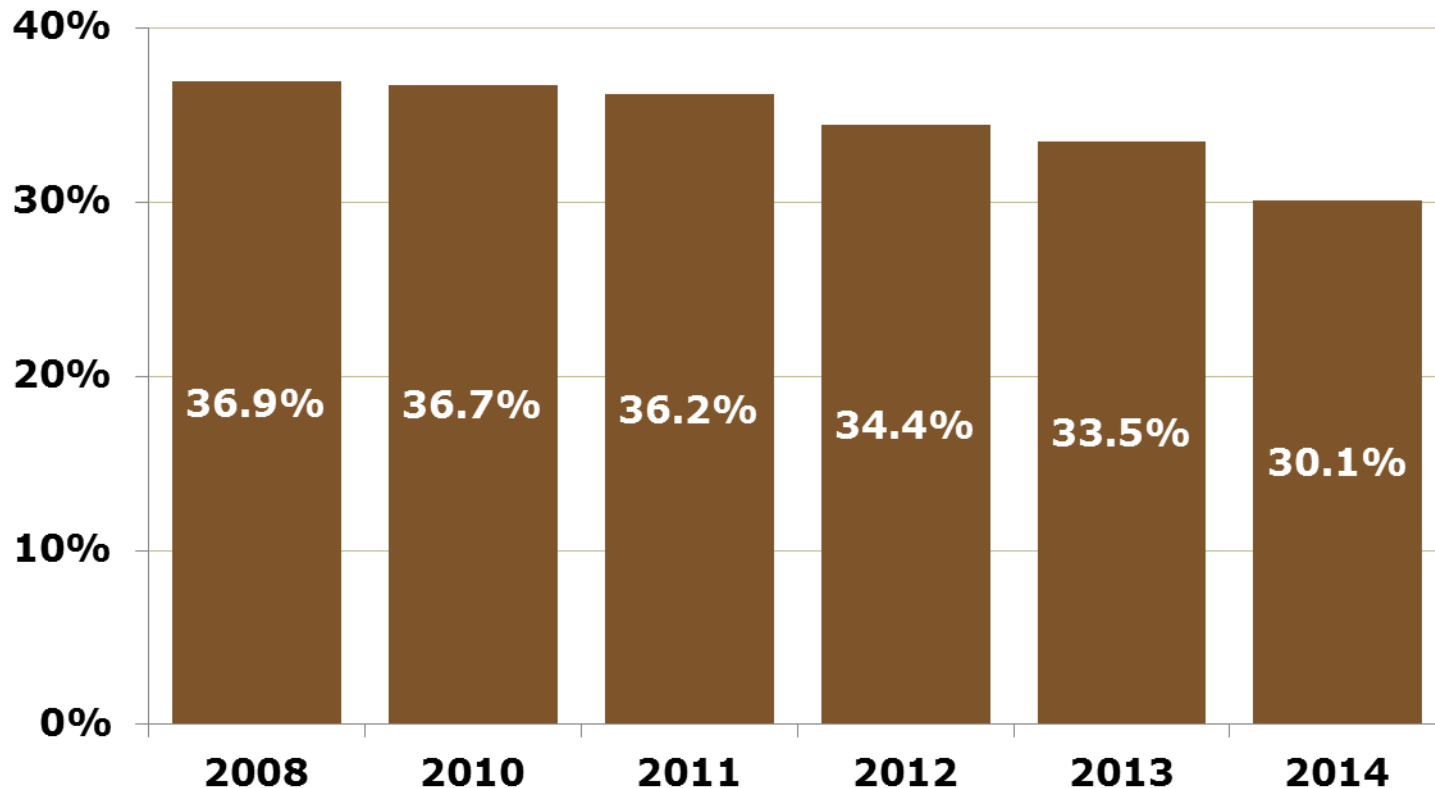
Unemployment Rate Impacts Public Assistance





Low Wages Impact Self-Sufficiency

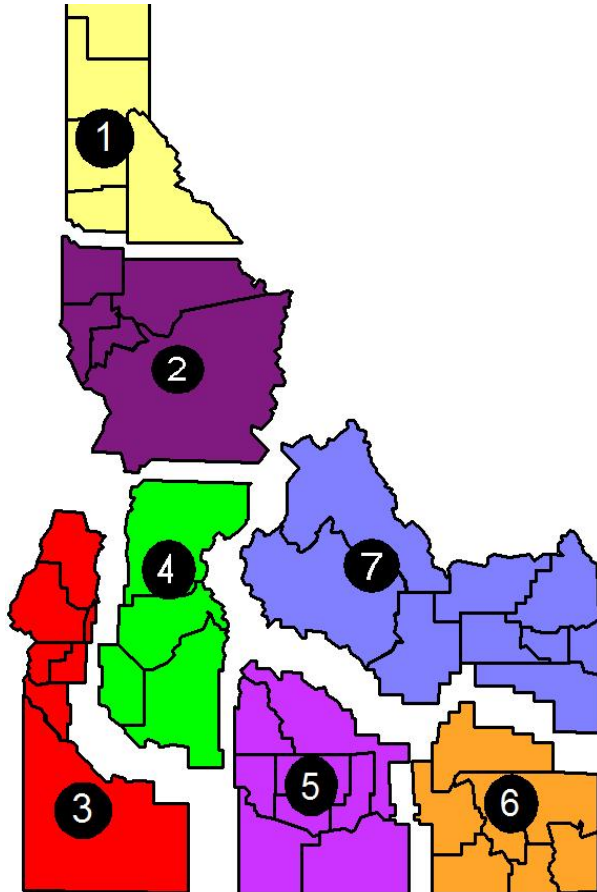
Percent of Idaho Jobs Paying Self-Sufficiency Wages for Family of 4
Subsistence wage = \$20.30/hr.



Source: Idaho Department of Labor



Public Assistance by Region 2014



Percent Receiving Assistance	
Region	Percent
1	20.4%
2	15.9%
3	28.0%
4	15.7%
5	22.5%
6	22.2%
7	21.6%
State Avg.	20.6%

The logo features the word "IDAHO" in a large, bold, black serif font. The letter "A" is stylized with a diagonal slash. The background of the logo is a photograph of a mountain range with a lake in the foreground, reflecting the mountains and sky.

IDAHO

Department of
Health and Welfare

**Idaho Department
of Health & Welfare**

Budget Presentation

**Richard Armstrong
Director**

February 12, 2015



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Depart. of Health and Welfare Director Richard Armstrong
Budget Presentation for Health and Welfare Committees 2-12-2015

Mr. Chairman, members of the committee, good morning.

Today, I want to present a high level review of the budget recommendation for the Department of Health and Welfare. I think you will find the recommendation adds up to a maintenance budget overall, along with several significant opportunities to improve the health and safety for our citizens.

Slide 2:

In this presentation, I will cover these five topics and then answer any questions.

The first is the State Healthcare Innovation Plan, which we refer to as the SHIP. We received a federal grant last month, which can help us improve the healthcare for all Idahoans.

Second, I will update you on our specific budget requests.

Third, we are beginning to see increased employee turnover as the economy recovers and jobs become available, and pay is the main issue. An employee CEC is vital for us to retain our valued workforce.

Fourth, we share eligibility services with Your Health Idaho. I want to update you on our performance.

Last, even though the state unemployment rate continues to improve, we are still experiencing extremely high workloads. I would like to share information on that.

Slide 3:

Let's start with a brief overview of our budget recommendation. Overall, this is a maintenance budget with several opportunities that I consider to be smart governance.

You'll notice our overall budget has increased 3.3%, equaling almost \$83 million. This is a large amount of money in anyone's book. However, if you subtract the non-discretionary adjustments, the CEC, employee benefit costs, and the federal SHIP grant recommendation, the actual increase is much smaller, closer to 1 percent.

The increase in receipts is 32 percent, due mostly to new federal regulations in Medicaid, which require us to collect an estimated two years of hospital settlements in 2016.

Slide 4:

As you can see from this slide, Medicaid continues to be four-fifths of our budget, which has not changed much from last year. One thing that has changed on this chart is in the lower right-hand corner. We propose a new program called Healthcare Policy Initiatives to replace the Medical Indigency program.

The Medical Indigency Program funded our activities to reduce the costs to the counties and the state for indigent healthcare. We propose transitioning to Healthcare Policy Initiatives to expand our vision and scope to a new level, one that can improve healthcare and lower costs for all Idaho citizens.

We have accomplished all we can for controlling indigent healthcare costs within that program's framework. Now we have the opportunity to think bigger with Healthcare Policy Initiatives. We can now do something extraordinary for the healthcare system as a whole through the Idaho SHIP initiative. We will talk about that in a few minutes.

Slide 5:

The percentage distribution of our funding is largely unchanged from last year. Eighty-five percent of the appropriated funding goes to the private sector for their services and goods.

Slide 6:

The evolution toward a more sustainable and effective healthcare system began back in 2007. Our agency became very involved with this initiative because Medicaid is one of the larger insurers in the state, covering almost 270,000 Idahoans today.

As you know, many of Medicaid's participants have serious illnesses or disabilities that can result in very high costs. Because of this, one of our department's early emphases was to transition Medicaid participants to health homes and care management solutions. The health homes are extremely important for helping us manage expensive, chronic conditions.

For care management, Medicaid now has programs in transportation, dental, and behavioral health services. Our vision is to transition all Medicaid participants to care management, so people receive the most appropriate and evidence-based services at the right time and for the right cost.

Idaho was awarded the SHIP grant last month—it is a four year grant for almost \$40 million. Idaho's SHIP proposal for transforming our healthcare system is based on the patient-centered medical home. This is the model we have been focusing on for years in Medicaid. It helps refocus our healthcare system on the benefits of primary care.

Slide 7:

In this patient-centered medical home model, a primary care provider and his or her team coordinate all of a patient's needs. This includes management of chronic conditions, visits to specialists, hospital admissions, and reminding patients when they need checkups and tests.

Medical homes make extensive use of electronic health records to track medications and tests. They also collect outcome data to evaluate how a patient's health has been affected by specific treatments. This outcome data will be extremely important in the future, as we share best practices with other providers, so they too can achieve better outcomes and lower costs.

The payment model for patient centered medical homes also changes. Today most insurers and Medicaid pay a straight fee-for-service claim for each treatment that is given. With the SHIP model, medical providers receive a per-member-per-month fee for managing the care of their patients.

Other states are conducting similar reforms and showing great success. Adults with primary care physicians have much lower costs of care, especially if they have chronic conditions such as diabetes, heart disease or asthma.

They are less likely to receive unnecessary tests or seek ER treatment for a non-emergency, and have fewer hospital admissions. With expanded use of electronic health records, their prescriptions are more easily monitored by their primary care physician so there are fewer adverse effects or prescription abuse.

Slide 8:

In Idaho, we conducted a pilot of Medicaid adults with chronic illnesses to see how a health home affected their hospital use. During the two-year pilot, we reduced hospital admissions by 26 percent, hospital readmissions by 41 percent and Emergency Room visits by 24 percent. We are still analyzing the data, but overall we saved an average of 20 percent during the pilot.

We paid the health home a monthly fee to manage these participants, with preliminary data showing a 10/1 return on this investment. Now these Medicaid participants in the pilot were some of our most chronically ill and expensive participants who would greatly benefit from coordinated, care management.

With the general Medicaid population, we expect savings and improved outcomes, too. But we will probably not realize such a high rate of return as this pilot population.

Slide 9:

The grant is for \$39.6 million spread over four years. We are asking for spending authority for \$8.9 million of the grant for SFY 2016, which will be administered by the Healthcare Policy Initiatives program.

With that funding, we will begin the transition of 165 primary care practices to the medical home model, targeting one-third, or 55 of them, in 2016.

We also will use grant funding to connect these practices' electronic health records to the Idaho Health Data Exchange, which is very important to manage the patients and collect outcome data. The Idaho model for the grant relies heavily on developing regional collaboratives to support local, coordinated care.

Our plan is to work with the seven Idaho public health districts to achieve this, which will mutually benefit all of us as we work to improve the overall health in each of our communities.

Slide 10:

Next, I would like to present our budget requests. I'll start with our supplemental requests for SFY 2015. First, we are requesting \$615,000 for the plaintiff's attorney fees for the Jeff D. lawsuit. This is a lawsuit concerning children's mental health services that have been going on since 1980.

There were two primary issues:

1. Mixing of adult and juveniles at the State Hospital, which has been remedied.
2. Providing community-based mental health services, which has been the primary focus since 1990.

The case was actually dismissed by the courts in 2007, but reinstated on appeal in 2011.

We have been in confidential mediation since October 2013 to develop an agreement that we hope will lead to a mutual request for dismissal. A draft agreement is currently under review by all parties, which is very good news for all of us.

Slide 11:

Our next supplemental request is for a hepatitis C drug treatment that can cure the disease. Prior to this treatment, people infected with hepatitis C either died or underwent a liver transplant. The drug is only effective with specific genotypes of hepatitis C, so we require prior-authorization for treatment.

This is an expensive treatment; however, state Medicaid programs are required to pay for FDA approved drugs when medically necessary. There may be an opportunity to reduce this cost, for there are new, similar drugs coming onto the market. We are exploring possibilities to do this.

Slide 12:

We were awarded a substance abuse treatment grant last October that is targeted for three specific populations.

1. Veterans who are involved in the criminal justice system and on parole
2. Families involved with child welfare, in which part of their problem is substance abuse
3. People who are homeless.

All told, this grant is projected to help 3,400 Idahoans with substance use disorders over the next three years.

Slide 13

Next, I would like present our SFY 2016 requests

I want to thank you for appropriating funds last session for the development of a Behavioral Health Community Crisis Center. I am happy to report that the Crisis Center opened successfully in Idaho Falls last December. This year, the Governor is recommending funding for a second crisis center.

The purpose of the crisis center is to provide a safe, voluntary, effective, and efficient alternative to emergency rooms and jails for people suffering a behavioral health crisis. Hospitals, counties, cities, and the state should all realize savings from the crisis center. It can save on law enforcement resources, county indigent funds, emergency department services to uninsured patients, as well as reduce court-ordered civil commitments.

The contract we developed with Bonneville County for operation of their crisis center requires them to develop a plan to cover 50 percent of the operating funds within two years. It is critical we work with communities opening crisis centers so they contribute local funding to the greatest extent possible.

Future crisis centers will have the same contract requirement. It may be a challenge for communities to generate enough funding to cover 50 percent of costs. But we believe communities need to have "skin in the game" to sustain the crisis centers and to ensure they have the greatest possible impact for the people and communities they serve.

Slide 14

Last legislative session, we agreed to expand our Food Stamp benefit distribution from one day to 10 days. We had been providing the benefit on the first of each month, but will now go to the first 10 days of each month. The annual cost is estimated at \$211,400 per year.

Initially during the first year, we have one time costs for computer programming, mailings of public notices to participants, and new card embossing machines. We are covering these one-time costs with a bonus we earned for high performance in the food stamp program.

Slide 15:

Our next request is for our licensing and certification program that licenses nursing homes, assisted living facilities, hospitals, certified family homes and others. We are having a difficult time retaining trained workers, due primarily to stress and workload.

We are working hard at improving productivity and efficiency, but we are barely avoiding financial penalties for meeting federal performance standards. As of December 31st, we had 275 overdue surveys and 135 open complaints that require investigation. We also anticipate conducting over 3,100 surveys during 2015.

As baby boomers age and need these types of facilities, the workload will continue to increase.

Slide 16:

Community hospitalization treats patients who are committed to the state and waiting for an open space to become available at a state hospital. We negotiate with the hospitals individually, but overall, it will be about a 10 percent increase.

The hospitals are not renewing contracts at the current rates, but have agreed to short-term contract extensions with this request being made.

Slide 17:

We have been very successful in finding adoptive homes for children who cannot safely live with their families. Many of these children have suffered from the trauma of abuse and neglect, so finding adoptive families for them is a major victory in their lives.

We provide a monthly stipend for adoptive families, because many of these children have special needs due to the abuse or neglect they suffered. We also have experienced a decrease in the federal funding, which shifts some of the costs to the state.

Adoptions have a life-long, positive impact on children. The alternative is perpetual foster care until a child ages out at 18 years, which also can have a lifelong impact on a child. But that is not as positive, and can be more expensive in the long run.

Slide 18

Currently, we are experiencing a high rate of turnover among our scientists at our state lab. An analysis shows us that our workers' average earnings are 23 percent less than surrounding states and the private sector.

Our inability to retain public health scientists diminishes Idaho's ability to respond to health threats like Influenza, Rabies, Anthrax, and Ebola. We will target the majority of funding for mid-level scientists, and also use some for hard to recruit positions.

Slide 19

Idaho uses an assessment program with insurance companies to buy children's immunizations. Idaho insurers are assessed an amount per child they cover and they pay into the fund to purchase the vaccines, at a greatly reduced cost. There are 8 other states with similar assessment programs.

TRICARE is a federal insurance program for military personnel and their families, but they stated they are unauthorized to pay into state vaccine assessments like other insurers. We are now partnering with the state of Washington, which is in the same boat, in trying to work out an equitable solution. But until then, none of us wants to put the children of our military men and women at risk.

Slide 20

The Governor is recommending a 3-percent salary increase this year. We have been working hard to reduce turnover, but as you can see from this chart, we saw a slight increase in 2014.

Our turnover rate had been declining since 2011, primarily because there were fewer job opportunities available during the recession.

But that is changing.

In exit interviews with workers taking jobs in the private sector, over half identified pay as the main or contributing factor in their decision to leave. They also reported their average pay increase in the private sector was substantial, averaging 38 percent.

I know we cannot compete with the private sector on pay alone; but we need to be in the ball park. Over 30 percent of our turnover in 2014 was with workers who had less than two years of service. 57 percent included workers with less than six years.

We don't want to become the training ground for the private sector. It is expensive to train someone in a position, just to see them leave as their skills reach a productive level. Our workload remains high, and we cannot afford to lose talented workers.

We urge your support for the Governor's 3-percent recommendation.

Slide 21:

Next, I want to talk with you about the eligibility services provided to Your Health Idaho, the state's insurance exchange. Undoubtedly you have followed the national news stories about the high cost and low success rates of state insurance exchanges throughout the country.

Congressional research shows that most states that implemented state exchanges have costs climbing well over the hundred million dollar mark.

In November, Idaho implemented our own Insurance Marketplace, doing so at less than half the cost of most states. With just over 2 months under our belt in operations, Idaho has one of the most effectively operating exchanges in the country.

You may wonder why?

Because other states have struggled and even failed due to the complex functionality of their eligibility systems. On this chart, you can see that five states that committed to state exchanges are not operational, primarily because of eligibility system problems. Oregon, after spending more than \$200 million, pulled the plug in April because of failed technology and is no longer pursuing a state exchange.

In Idaho, we figured it out.

Our agency's eligibility services are recognized nationwide for being efficient and accurate. Rather than attempt to re-invent this system for the State Exchange, Idaho leveraged its high-functioning eligibility system to include determinations for tax credits. We call this model "Eligibility Shared Services".

As of October 2014 Your Health Idaho was approved for \$70 million in federal funds to build its exchange.

The development costs for DHW to provide eligibility shared services for the exchange is expected to total \$14 million over a two year period.

Slide 22:

That brings us to our request for receipt authority from Your Health Idaho to cover those development costs, along with ongoing operations. This has been a very pragmatic and successful operation to date. Shared services not only allowed Idaho to implement an exchange quickly, but also ensured that we built Idaho's investment on proven technology, minimizing risk and maximizing functionality.

Throughout this process, we have been extremely careful to meet the legislative intent that no state funds will be used to implement Idaho's Exchange. That was the legislature's direction, and it has been strictly adhered to.

Slide 23:

Your Health Idaho went live on November 15th. Open enrollment was supposed to begin operations on October 1, but was delayed by six weeks. This caused problems and system bottlenecks as brokers and consumers raced to meet the enrollment deadlines.

However, even with the rollout of a newly adapted system and the shortened enrollment period, DHW determined tax credits for almost 95,000 people to date. By sharing eligibility services, Idaho was able to do what no other state accomplished in 2014—we successfully converted from the federal marketplace to our own state exchange.

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Slide 24:

One advantage we are realizing with sharing the same eligibility system is new data we are gleaning. Along with determining tax credits for Your Health Idaho, our system also determines eligibility for public assistance programs that include Medicaid, Food Stamps, cash and child care assistance.

By analyzing system data that takes a global view of participants in each program, we have identified approximately 53,000 people below the poverty limit who are not receiving Medicaid or a tax credit. They are part of the Gap population I spoke to you about last Thursday. I provided you with a map that showed our estimates for each county.

This is the first time we have actually been able to put a human face on who the Gap population are. These are Idaho citizens who have no access or options for healthcare.

Slide 25:

Both our national and state economies are recovering, which is great news. However, the number of Idahoans receiving public assistance remains high, even as unemployment falls.

We believe it goes back to the wages—people are working, but they are not earning a livable wage and they still qualify for public assistance. This chart shows the number of Idaho citizens receiving public assistance through Medicaid, Food Stamps, child care or cash assistance programs.

In 2006, only 14 percent of our state's population received some form of this public assistance. We were at full employment. But then the recession hit. Unemployment reached double digits across our nation.

Like other states, Idaho experienced huge increases in people needing public assistance for their families. No one was exempt; it affected all of us in some way. Our agency is still feeling its effects. In 2014, the percentage of Idahoans receiving public assistance increased to 20 percent.

Slide 26:

This shows a little bit different view. Medicaid is the blue line. It shows a pretty steady increase over the last eight years. Idaho has pretty restrictive eligibility requirements, so much of the increase is in children from low-income households.

Food Stamps, on the other hand, are often considered a barometer of the economy. It is the red line. When we went into the recession, unemployment more than doubled, with Food Stamp enrollment mirroring a similar increase, delayed by several months. People tried to get by, but couldn't without some assistance.

Now as the economy recovers and unemployment drops to near pre-recession numbers, Food Stamp enrollment is declining. But it is not declining at the numbers we might anticipate looking at the historical trend.

Why? Because people are back to work, but they aren't earning a livable wage. They still qualify for Food Stamps. They don't get as much in benefits, but they are still struggling to get by.

Slide 27

The Idaho Department of Labor estimates the number of jobs that pays subsistence wages, so no public assistance is necessary. For a family of four, a subsistence wage in Idaho is estimated at \$20.30/hour. If you look at this chart, only 30 percent of Idaho jobs pay subsistence wages for a family of four.

That means 70 percent do not. That percent of Idaho jobs that can support families has been slowly declining due to the recession. This is the reality our programs and workers are dealing with on a daily basis. People are working, but they are not earning enough to meet the basic needs of their families.

Slide 28

With this slide we can see that the need for public assistance varies throughout the state. The lowest use areas are regions 2 and 4. The highest are regions 3 and 5. We have adapted our systems and procedures to handle the increased workload. But we all know the long-term answer is livable wages for Idaho workers.

Gov. Otter's Accelerate Idaho strategic plan sets the course for creating new opportunities for our citizens and communities. I also sense a powerful commitment in this body not only for future economic growth and development, but also in our education system to fuel a vibrant, self-reliant workforce.

We are confident we are on the right path, but it may take some time before the utilization of public assistance services returns to pre-recession levels.

Until then, we will continue to do everything we can to help our citizens achieve self-reliance.

That concludes my presentation. I would be happy to answer any questions.

BYLAWS OF THE IDAHO TIME SENSITIVE EMERGENCY SYSTEM OF CARE

ARTICLE I

NAME & PURPOSE

- 1.1 Name.** The name of this Council shall be the Idaho Time Sensitive Emergency (TSE) System Council.
- 1.2 Purpose.** The primary purpose of the Council is to develop, implement and monitor a statewide system that includes trauma, stroke and heart attack facilities.
- 1.3 Authority.** The Council is created pursuant to Idaho Code § 56-1027. Notwithstanding any other provision of law to the contrary, the Council shall exercise its powers and duties in accordance with the provisions of Idaho Code § 56-1024 through 56-1030, relative to establishment of standards and system oversight of the statewide time sensitive emergency system of care.

ARTICLE II

MEMBERS

- 2.1 Appointment.** The Council will initially be composed of eleven (11) voting members appointed by the Governor upon assurance of equitable geographic and rural representation.
 - 2.1.1** Three (3) representatives shall be from facilities holding or seeking designation as follows:
 - One (1) representative from a facility that either holds or is seeking designation as an Idaho trauma center. The representative may be the medical director, the coordinator or the program manager responsible for the respective facility's trauma program;
 - One (1) representative from a facility that either holds or is seeking designation as an Idaho stroke facility. The representative may be the medical director, the coordinator or the program manager responsible for the respective facility's stroke program;

One (1) representative from a facility that either holds or is seeking designation as an Idaho heart attack center. The representative may be the medical director, the coordinator or the program manager responsible for the respective facility's heart attack program;

2.1.2 Three (3) representatives shall be from EMS agencies as follows:

One (1) representative from an EMS agency licensed by the department that serves a primarily urban response area;

One (1) representative from an EMS agency licensed by the department that serves a primarily rural response area;

One (1) representative from an air medical EMS agency licensed by the department;

2.1.3 Two (2) administrators or chief executive officers from hospitals as follows:

One (1) administrator of an Idaho hospital that either holds or is seeking Idaho trauma, stroke or heart attack designation;

One (1) chief executive officer or administrator of an Idaho critical access hospital that either holds or is seeking Idaho trauma, stroke or heart attack designation;

2.1.4 Two (2) licensed health care providers who:

One (1) licensed health care provider who routinely works in the emergency department of a hospital that serves a primarily urban area that either holds or is seeking trauma, stroke or heart attack designation;

One (1) licensed health care provider who routinely works in the emergency department of a hospital that serves a primarily rural area that either holds or is seeking trauma, stroke or heart attack designation; and

2.1.5 One (1) Idaho citizen with an interest in furthering the quality of trauma, stroke and heart attack care in Idaho.

2.1.6 The chair of each regional TSE committee shall be added as a voting member of the council when the regional TSE committees are implemented and the chair of each regional committee is selected.

- 2.2 Terms.** Members of the council shall serve four (4) year terms with half of the members initially appointed, as determined by lot, serving two (2) year terms.
- 2.3 Vacancy.** If a vacancy occurs, the governor shall appoint a replacement to fill the unexpired term. Members may be reappointed and may be removed for cause by the governor.

ARTICLE III

OFFICERS

- 3.1 Election of Officers.** The governor shall appoint a Chair, who shall serve a term of two (2) years. The Council shall elect, by majority vote, a Vice-Chair and such officers as it may deem necessary and appropriate.
- 3.2 Terms.** Officers will serve a one (1) year term that shall commence on July 1 and end on June 30 of the following year. At the end of their term, officers shall be eligible for re-election. Elections shall occur prior to the expiration of the current term and as close as practicable to July 1.
- 3.3 Vacancy.** Upon a vacancy in any office other than the Chair, a replacement shall be elected by majority vote and the elected member shall serve for the remainder of the term of the vacated office.
- 3.4 Chair.** The governor shall appoint a chair who shall serve a term of two (2) years. The Chair shall preside at meetings of the Council and shall exercise such duties and powers as determined by the Council.
- 3.4.1** In the event that the Chair and Vice-Chair cannot be present to preside at a Council meeting, the Chair will identify a Council member to preside over a meeting. If the Chair is not able to or does not identify such Council member, the Council, by majority vote, will identify a Council member to preside over the meeting.
- 3.4.2** In coordination with the Bureau of EMS and Preparedness, the Chair shall keep correct minutes of the Council and furnish copies to each member of the Council.
- 3.4.3** In coordination with the Bureau of EMS and Preparedness, the Chair will prepare an agenda for each meeting of the Council.

- 3.5 Vice-Chair.** The Vice-Chair, in the absence of the Chair, shall preside over all meetings and exercise the duties and powers of the Chair, and shall exercise such duties and powers as determined by the Council.
- 3.6 Secretary.** The Council will elect a Secretary whose duties are to coordinate with the Bureau to assure accurate record-keeping regarding minutes and other Council business.
- 3.7 Treasurer.** The Council will elect a Treasurer to oversee any financial matters related to the TSE Council.
- 3.7.1** In coordination with the Bureau of EMS and Preparedness, the Vice-Chair shall prepare a budget on an annual basis indicating that portion of the moneys collected by the Bureau of EMS and Preparedness for designation of facilities that is necessary for the continuous operation of the Council.
- 3.7.2** In coordination with the Bureau of EMS and Preparedness, the Vice-Chair shall present the budget and a financial report to the Council at least annually.
- 3.8 Parliamentarian.** It is the responsibility of this officer to assure that meetings are run in accordance with the Idaho Open Meeting Law. This member may be ex-officio and does not have voting rights.

ARTICLE IV

MEETINGS

- 4.1 Open Meeting Law.** All meetings of the Council shall be subject to the Idaho Open Meeting Law, Idaho Code § 67-2340 through 67-2347.
- 4.2 Meeting Schedule.** The Council shall meet at least semiannually or at the call of the Chair.
- 4.3 Meeting Location.** The meeting locations may vary throughout the state to facilitate geographic access by each region. Meeting location will be determined by Council vote.
- 4.4 Quorum.** A majority of the members of the Council shall constitute a quorum for all actions. A quorum must be present for any official act of the Council. Members are strongly encouraged to participate in person. However, members may be present at a meeting by telephone, in accordance with Idaho Code § 67-2342(5).
- 4.5 Parliamentary Procedure.** *Parliamentary Procedure Made Easier* published by Washington State University or as the same shall be revised from time to time, shall

govern procedure of the Council except as otherwise required by statute or rule or by these Bylaws.

- 4.6 Voting and Proxies.** Each member of the Council has one (1) vote on any matter of business before the Council and may vote by proxy. A member (may include regional Chair and Vice-Chair) may send a representative if he or she is unable to attend a meeting and such representative may vote and may be counted for the purpose of determining whether a quorum is in attendance.
- 4.7 Establishment of Subcommittees.** By majority vote, the Council may establish working subcommittees in order to help it achieve its statutory mandates. Such subcommittees are advisory only and have no legal authority to act. Subcommittees shall not exceed five (5) Council members. Ex-officio members may be added to subcommittees as deemed necessary by the Council.
- 4.8 Order of Business.** The order of business at meetings shall be as follows:
- Approval of minutes
 - Financial Updates
 - Reports of officers
 - Reports of subcommittees
 - Unfinished (old) business
 - New business
 - Next meeting date
 - Adjournment
- 4.9 Conflict of Interest.** Whenever a Council member has a financial or personal interest in any matter coming before the Council, the affected person shall fully disclose the nature of the interest. The minutes of meetings shall record such disclosure.

ARTICLE V

COMPENSATION

Members of the Council shall be compensated as provided in Idaho Code §59-509(b).

ARTICLE VI

AMENDMENTS

- 6.1** Members may, by a two-thirds vote of all members, alter, amend, or repeal any bylaws adopted by the members at any duly held meeting of the Council.

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, February 16, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
<u>RS23569</u>	RELATED TO NURSES - Amending to provide Nursing Board members who have attained an additional degree may be reappointed	Chris Jenkins
<u>RS23419</u>	RELATED TO MUSIC THERAPY - Recognizing the value of Music Therapy	Chairman Heider
<u>RS23566C1</u>	Physician procedures within admitting privilege proximity	Chairman Heider
<u>RS23598</u>	RELATED TO NATIONAL DIAPER NEED AWARENESS - Recognizing national diaper need awareness week	Senator Janie Ward-Engelking
<u>RS23624</u>	RELATED TO FAMILY CAREGIVERS - Creating a task force to study issues relating to family caregivers	Peggy Munson AARP Idaho
<u>RS23632</u>	RELATED TO INDIGENT SICK - Amending to revise the declaration of policy relating to who is eligible for the County medically indigent program and catastrophic health care cost program	Senator Schmidt Senator Trujillo

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 16, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Johnson (Lodge), Nuxoll, Tippetts, Lee, Schmidt and Lacey

ABSENT/ EXCUSED: Senator Hagedorn

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Health and Welfare Committee (Committee) to order at 3:00 p.m. and welcomed everyone in attendance.

RS 23569: Relating to Nursing Board Appointments.

Chris Jenkins, registered nurse, began by stating that the legislation being amended has to do with membership of the Board of Nursing (Board). Currently, there is a penalty for lifelong and ongoing education. The amendment would give members of the Board who have attained an additional degree the opportunity to be reappointed to the Board position they were originally appointed to. Board membership is made up of three associate degree nurses, two bachelors degree nurses, one advanced practical nurse and one community representative. Once the current term on the Board is completed, a Board member is not allowed to be reinstated to the same position if additional education has been obtained.

Senator Nuxoll asked why education is connected to the terms. **Mr. Jenkins** stated it is basically a boundary issue. If you do not continue your education, you can get subsequent Board positions. You can reapply for a different position on the Board, but the position that you currently hold is not an option. **Senator Lacey** asked about the type of people on the Board. If someone is no longer an associate and becomes a nurse with a degree, does that negate the makeup of the Board. **Mr. Jenkins** said that the proposed change negates the current membership in that you advance your education, you still can represent the original degree level.

Chairman Heider asked who Mr. Jenkins was representing. **Mr. Jenkins** replied that he was representing himself as a Board member, and the Board chairman was aware of what his request was. **Chairman Heider** asked about Mr. Jenkins' standing on the Board if the legislation was printed as it is currently written. **Mr. Jenkins** replied that today it would not, but in two years when he has further education it would affect his Board position. **Chairman Heider** asked if he was correct in saying that the way the current Board is made up, as Mr. Jenkins advances in his position, it would open up other positions for incoming people to fill at a lower level. **Mr. Jenkins** responded that sometimes employers require additional education as part of their employment. This would cause Board members to have to relinquish their positions on the Board. The positions are staggered and multiple positions do not come open at the same time.

Vice Chairman Martin asked what the Board's position was on Mr. Jenkins' request to the change legislation. **Mr. Jenkins** stated that he was here on his own. **Senator Johnson (Lodge)** suggested that she would like to see a letter from the

Board as a body stating that they are behind this change. **Chairman Heider** asked again if Mr. Jenkins represented himself or the Board. **Mr. Jenkins** said that he was testifying on his own behalf, but the chairman and the executive director were aware of his testifying.

MOTION: **Vice Chairman Martin** moved to print **RS 23569**. **Senator Nuxoll** seconded the motion.

SUBSTITUTE MOTION: **Senator Tippetts** moved that **RS 23569** be returned to the sponsor.

Senator Tippetts suggested that the makeup of the Board is designed for a reason, and if a person is appointed to fill a particular position and later doesn't meet that criteria, then someone else should be appointed to that position.

Senator Nuxoll withdrew her second of the original motion.

The motion carried by **voice vote**.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin.

RS 23419 Relating to Music Therapy.

Chairman Heider began by stating that there are less than 24 music therapists in Idaho. They are asking to be recognized as having value to the therapeutic community. Chairman Heider attended some of those sessions and saw improvement in the participants.

MOTION: **Senator Lacey** moved to print **RS 23419**. **Senator Schmidt** seconded the motion.

Vice Chairman Martin asked for discussion on the motion. **Senator Lacey** said that he strongly favors this resolution.

The motion carried by **voice vote**.

RS 23566C1 **Chairman Heider** presented **RS 23566C1**. This bill was previously sent to print. To be in agreement with the national standard, a physician had to be within 30 miles of the hospital to be given admitting privileges. In the original bill "abortion" was listed and upon recommendation was changed to "surgical abortion." **Senator Lee** indicated that the statement of purpose should include the word "abortion" so that it more accurately reflects the intent of the legislation. **Senator Heider** indicated that he wasn't aware of that when the statement of purpose was written. At this point he felt the current statement of purpose would stand. **Vice Chairman Martin** said that the proposed wording was included in the last motion and should be included in the current one. **Senator Tippetts** stated that he was the one who made the motion to print the RS with the understanding that the sponsor would amend the statement of purpose to state specifically "abortion" as opposed to the more general surgical procedures. He supported Senator Lee in her request and stated changes should be included in the motion to print.

MOTION: **Senator Tippetts** moved to print **RS 23566C1** with the stipulation that the sponsor will amend the statement of purpose to refer specifically to abortions. **Senator Schmidt** seconded the motion.

Senator Tippetts suggested that a full hearing be held to see if this would be appropriate.

The motion carried by **voice vote**.

RS 23598 Relating to National Diaper Need Awareness.

Senator Ward-Engelking presented **RS 23598**, a concurrent resolution to promote Diaper Need Awareness Week. She turned her time to Shawna Walls, Executive Director and founder of Idaho Diaper Bank. Ms. Walls said diaper need is a crisis nationwide and particularly in Idaho. There are 35,000 children ages 3 and under who are living in low income or poverty. Studies show a link to abuse and neglect when diapers are not available. The Idaho Diaper Bank was formed as an Idaho non-profit charitable organization. Its goal is to get a million diapers out to help supplement the need in Idaho. There is zero government assistance for diapers. By promoting Diaper Need Awareness Week, Idahoans will get their communities more involved in this effort. **Senator Ward-Engelking** asked for the Committee's support on getting the RS printed.

Senator Nuxoll commented that she felt that state money was being used for things that could be made aware of in other ways. **Senator Lee** stated that there is no fiscal impact for this, it is for awareness only. She feels this is an excellent way to support the community.

MOTION: **Senator Lee** moved to print **RS 23598**. **Senator Lacey** seconded the motion.

Senator Johnson asked if there were any plans to change the status of food stamps to being used for diapers. **Senator Ward-Engelking** responded that it is just to build awareness for a diaper bank.

The motion carried by **voice vote**. **Senator Nuxoll** asked to be recorded as voting nay.

RS 23624 Relating to Creating a Task Force to study issues relating to Family Caregivers.

Peggy Munson, retired geriatric nurse and past volunteer state president of AARP of Idaho, indicated that there are approximately 200,000 people providing an estimated \$2 billion worth of unpaid care to family, friends and loved ones. As the demographics shift and the population ages, that number will grow. This resolution seeks to raise awareness about uncompensated family caregivers and the critical role they play as part of the state's healthcare and long-term care system (see attachment 1).

Senator Lee asked for clarification on the fiscal note attached to this resolution. **Lee Flinn**, Advocacy Director for AARP Idaho, responded to the question. She indicated that a discussion was held with Senator Heider and the Pro Tem. If a Legislator participates in the task force, their per diem would be paid from the Legislative Fund. Initial discussions indicate that there could be possibly four Legislators participating; other costs would be covered by AARP Idaho. **Senator Tippetts** agreed that there should be some Legislators serving on the task force, and that should be noted in the fiscal note. He suggested that the statement of purpose be amended to more accurately reflect the fiscal note.

MOTION: **Senator Lacey** moved that **RS 23624** be printed and brought back to the Committee for further discussion on the fiscal note. Changes should reflect that travel costs for Legislators would be paid out of the Legislative Fund and also to correct the spelling of Lee Flinn's name.

The motion carried by **voice vote**. **Senator Nuxoll** asked to be recorded as voting nay.

RS 23632 Relating to Indigent Sick.

Senator Dan Schmidt presented **RS 23632**. Senator Schmidt is on the board for the State Catastrophic Health Fund. This legislation addresses the issue of people who may be medically indigent. Medical indigency, by statute, is determined by county commissioners. **RS 23632** is trying to direct that determination.

Currently people are declared medically indigent if they can't pay for medical bills they have incurred over a subsequent five year period. This legislation addresses the question of whether they could have insurance. Studies have shown that some people who have had their medical bills paid through this determination could have been covered by insurance. Representative Trujillo and Senator Schmidt encourage these people to enroll in insurance.

The population is split into three groups. Those below 100 percent of the federal poverty level are not able to participate in the exchange and would still be under the current rules for indigents. Those above 138 percent of the poverty level would not be considered indigent. They are eligible to participate in the exchange and buy insurance. The group between 100 percent and 138 percent of the poverty level are eligible to participate in the insurance exchange. If they choose not to participate in the exchange, they will not be eligible through this legislation to be considered in the indigent category. If they weren't eligible for the exchange, then they are eligible to be covered as an indigent by the county. This act will take full force March 2016 which is the end of the enrollment period next year. The goal is to encourage people who can enroll in insurance to do so. **Senator Schmidt** said that there is evidence to show that this is working because people who are eligible are enrolling in the insurance exchange.

Senator Nuxoll asked for clarification that those who are between 100 and 138 percent of poverty level are the ones who need to buy insurance. **Senator Schmidt** reiterated that those above the 138 percent level would not be considered eligible for indigent coverage. Between 100 and 138 percent people are considered on case-by-case basis whether they could have been enrolled or not. There is a significant amount of eligibility determination that needs to be considered.

Senator Nuxoll asked if those below 100 percent could go on Medicaid. **Senator Schmidt** indicated that in the State of Idaho, people who are single and do not have children are not eligible for Medicaid. **Senator Tippetts** questioned the fiscal note regarding the estimated 1200 cases. **Senator Schmidt** responded that his concern is warranted. That number was arrived at with the current population of this group of people and it is shrinking. The 1,200 cases are estimated and that may change by the time 2016 is reached. People in this group are signing up for insurance, so it may be less over the course of time.

MOTION: **Senator Nuxoll** moved to print **RS 23632**. **Senator Heider** seconded the motion.

Senator Tippetts stated that he is going to support the motion, but he had concerns about the approximate savings of \$11 million to the State and \$5 million to county taxpayers. Someone is still going to pay the cost. This is a cost shift not a cost savings.

The motion carried by **voice vote**.

PASSED THE GAVEL: Vice Chairman Martin passed the gavel to Chairman Heider.

ADJOURNED: There being no further business at this time, **Chairman Heider** adjourned the meeting at 3:46 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Asst. Secretary

February 16, 2015 – Remarks to Senate Health & Welfare Committee

Chairman Heider and Members of the Committee,

My name is Peggy Munson, I am retired geriatric nurse and past Volunteer State President for AARP Idaho.

I am here today to present RS 23624, a resolution pertaining to family caregiving – on behalf of AARP Idaho and the Idaho Caregiver Alliance.

The Idaho Caregiver Alliance a state-wide consortium led by the Idaho Commission on Aging and the Boise State University Center for the Study of Aging. There are approximately forty active members of the Alliance, including organizations such as the Idaho Alzheimer's Planning Group, Idaho Rural Health Association, Friends in Action, Disability Action Center and many more.

Caregiving is something almost everyone in this room will experience at some point in our lives – either as givers of care, or as recipients of care.

According to an AARP Public Policy Institute report called “Valuing the Invaluable: The Economic Value of Family Caregiving” – In Idaho there are approximately 200,000 people providing an estimated \$2 billion worth of unpaid care to family, friends and loved ones.

And as the demographics shift and the population ages, that number will grow.

This resolution seeks to raise awareness about uncompensated family caregivers and the critical role they play as part of our state's healthcare and long-term care system.

The resolution will also create a Task Force to coordinate and develop a comprehensive set of recommendations to inform stakeholders regarding innovative solutions to support uncompensated family caregivers in Idaho and to provide information to those who may serve as caregivers in the future.

The Task Force will compile an inventory of resources available to family caregivers and report its findings to the 2016 legislature.

On behalf of AARP Idaho and the Idaho Caregiver Alliance, we respectfully ask that you print this resolution and we thank you for your consideration on this important topic.

I'd be happy to answer any questions.

Peggy Munson
Boise, Idaho

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, February 17, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
H0004	RELATING TO CONTROLLED SUBSTANCES	Mark Johnston Board of Pharmacy
H0005	RELATING TO PHARMACY	Mark Johnston Board of Pharmacy
H0006	RELATING TO PRESCRIPTION DRUGS	Mark Johnston Board of Pharmacy
H0007	RELATING TO CONTROLLED SUBSTANCES	Mark Johnston Board of Pharmacy
H0008	RELATING TO PHARMACISTS	Mark Johnston Board of Pharmacy
H0009	RELATING TO UNIFORM CONTROLLED SUBSTANCES	Mark Johnston Board of Pharmacy

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
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MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 17, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Nuxoll, Hagedorn, Tippetts, Lee, Johnson (Lodge), Schmidt and Lacey

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.

H 0004 **Mark Johnston**, Executive Director, Board of Pharmacy (BOP), Department of Health and Welfare, explained Idaho Code required every person who manufactures, distributes, dispenses, or conducts research with controlled substances (CS) to annually obtain a registration issued by the BOP. If a registrant is found negligent, Idaho Code allows the BOP to suspend or revoke their registration. He said the BOP believes some violations that deserve a penalty did not rise to the level of suspension or revocation.

Mr. Johnston said **H 0004** would grant the BOP the authority to restrict CS registrations and enforce stipulated agreements that restrict CS registrations. Additionally, **H 0004** would allow the BOP to impose a fine of up to \$2,000, which is the current fine ceiling in the Idaho Pharmacy Act. Over the past two years, the BOP has fined an average of \$525 per order. Fines are a lesser penalty to utilize in certain cases to deter recidivism, where suspension and revocation are sometimes too harsh as penalties. He reported **H 0004** contains many changes that were initiated by an increasing need to restrict CS registrations for those prescribers who divert CS, and he urged the Committee to send **H 0004** to the floor with a do pass recommendation.

Vice Chairman Martin asked how the BOP would decide how much to fine an individual. **Mr. Johnston** replied each case was unique, but the BOP liked to act consistently as a deterrent to potential future abuse. He said fining the maximum was not the BOP's philosophy.

Senator Schmidt asked if licensed midwives were considered prescribers.

Mr. Johnston said there were two kinds of midwives in Idaho. Midwives who are advanced practice nurses, certified nurse anesthetists, and nurse practitioners have prescriptive authority. Midwives who do not have the qualifications do not have prescriptive authority. **Senator Schmidt** said he remembered giving midwives authority to dispense drugs during labor. **Mr. Johnston** said he was correct. What they obtained was the ability to obtain and administer prescription drugs, but they did not get the ability to prescribe drugs.

Senator Tippetts asked if, with passage of this legislation, the BOP would be able to impose a fine and, in addition, collect the costs of prosecution, attorney fees, administrative costs, and costs of hearing transcripts. **Mr. Johnston** said that was partially correct. The BOP has the ability to recoup their costs when they go to a proceeding such as a hearing. When they restrict pursuant to a stipulation, they do not have the ability to recoup their costs. **Senator Tippetts** asked him to explain. **Mr. Johnston** said they did not have the ability to restrict registrations. They have had the ability to suspend and revoke registrations, so the initial focus of this bill is to obtain the ability to restrict registrations. They would actually have to bring somebody into a BOP hearing or a proceeding to be able to recoup costs. **Senator Tippetts** asked if other boards had the authority, in addition to levying fines, to also recoup the costs that were enumerated. **Mr. Johnston** could not speak for any other board. **Senator Tippetts** asked Mr. Johnston to explain the meaning of stipulation. **Mr. Johnston** explained instead of bringing every person who potentially could be disciplined before the BOP in a hearing or hiring a hearing officer to create findings of fact and conclusions of law to present to the BOP, the law allows for the administrative agency and the registrant to come to a stipulated agreement where both agree to the violation and the stipulated penalty. It is quicker and cheaper for all. He said they do not have this ability for CS registrants. They do in the Idaho Pharmacy Act and almost every other agency probably has the ability to stipulate, so it is odd that they do not have it in the Uniform Controlled Substances Act.

Senator Hagedorn said the language "or conduct research with" was in one place but not mentioned in other places in **H 0004**. He asked Mr. Johnston to clarify. **Mr. Johnston** said originally it was left out of the statute then added at the end as an afterthought. This change strikes the language at the end of the bill and includes it in the main part of the bill. **Senator Hagedorn** suggested the BOP should have Legislative Services (LSO) look at the rest of the statute for consistency and add the language "or conduct research with" everywhere it should be included so there was no question.

Senator Nuxoll asked what new groups were being added. **Mr. Johnston** replied they were not adding new groups. **Senator Nuxoll** asked a follow-up to Senator Schmidt's question on whether midwives were already included in this and if they had to register. **Mr. Johnston** said the nurse-midwives who were advanced practical nurses with prescriptive authority were subject to it. Other midwives who had the ability to obtain and administer a small amount of prescription items pursuant to a formulary would not have to register because that formulary did not include CS.

Senator Tippetts asked why the BOP needed the ability to not only recover the costs but impose an additional \$2,000 on top of that. **Mr. Johnston** replied because they could not currently fine when they stipulated and because they believed a fine penalty decreased the amount of recidivism by the people who received the fine and by people who read about the fine in the BOP order and newsletters.

Vice Chairman Martin asked what actions by prescribers would be cause for a fine. **Mr. Johnston** responded there was a wide variety and gave a number of examples. Being able to impose a fine would give the BOP an alternative to suspension or revocation, depending upon the severity of the offense.

MOTION:

Senator Schmidt moved to send **H 0004** to the floor with a **do pass** recommendation. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**. **Senator Nuxoll** requested that she be recorded as voting nay. Senator Schmidt will carry the bill on the floor.

QUESTION: **Senator Johnson (Lodge)** asked how many members are on the BOP. **Mr. Johnston** explained the BOP has five members. Four members have to be active pharmacists, one of whom has to have substantial experience in hospital pharmacy, one has to have substantial experience in retail pharmacy and the other two can be mixed. The fifth is a member of the public who needs no ties to pharmacy.

H 0005 **Mr. Johnston** said Idaho Code requires the BOP to fingerprint applicants in order to check the Idaho Central Criminal History and Federal Bureau of Investigation (FBI) databases. The process often takes up to six weeks unlike other states. While the BOP believes fingerprinting is a useful tool for licensure and registration, a six-week delay is often a considerable public safety issue as pharmacies work shorthanded. **H 0005** would waive the fingerprint requirement for applicants seeking reinstatement whose license or registration has lapsed by less than a year. He urged the Committee to send **H 0005** to the floor with a do pass recommendation.

Senator Hagedorn asked who the BOP was removing from the list. Previously it said all applicants and now there were only three different groups. Who are they now leaving out of that and why? **Mr. Johnston** said it was a small group of people who are the designated representatives of a wholesale distributor who is not a licensee or a registrant. That would become more apparent in the discussion of **H 0008**.

Senator Tippetts asked why someone would have to be fingerprinted again if they had been fingerprinted before. **Mr. Johnston** said the FBI certifies their fingerprint background check for six months. When statute said they have to reprint someone who was being reinstated and it had been longer than six months since their last fingerprinted background check, they had to do the fingerprint-based background check again.

MOTION: **Vice Chairman Martin** moved to send **H 0005** to the floor with a **do pass** recommendation. **Senator Tippetts** seconded the motion. The motion carried by **voice vote**. Vice Chairman Martin will carry the bill on the floor.

H 0006 **Mr. Johnston** explained currently a prescription drug order may be communicated by telephone, fax, or hand-delivered by a prescriber or their agent to a pharmacy. He said the Drug Enforcement Agency (DEA) allowed electronic prescribing of controlled substances pursuant to considerable federal regulation and an expensive approval process. He said the BOP had championed a public request to legalize the electronic transmission of prescription drug orders by licensed practical or professional nurses in an institutional facility for a patient of that facility to a pharmacy via a secure interoperable information technology system. While the DEA will not allow this for CS, the BOP believes the benefit to public safety outweighs the potential for privacy violations. This system already exists in hospitals, whereby a physician at the patient's bedside can have their nurse enter an order into a computer system in which the pharmacy retrieves the data and dispenses the prescription. **H 0006** would allow such transmissions from nursing homes, just like in the hospital. The BOP championed a request from the public to run this bill, and one of the requesters, Bill Silvias, was present for the Committee to ask any technical questions. **Executive Director Johnston** said this change to Idaho Code was necessary to keep up with the advancement of technology.

Senator Tippetts asked where the word "may" was changed from "shall" in **H 0006**. **Chairman Heider** observed the only place was at the top of page 2, line 6.

Senator Schmidt asked how a midwife with only dispensing authority fit in this, since dispensing midwives do not have prescribing authority. **Mr. Johnston** said they did not fit because they were not prescribers and only had the ability to administer to the patient in front of them. They could not send take-home doses home. **Senator Schmidt** asked how a midwife obtains drugs. **Mr. Johnston** said in the Idaho Wholesale Drug Distribution Act, pharmacies are allowed to distribute, in the absence of a patient-specific prescription drug order, manufactured products to a prescriber for office use. Since midwives don't operate out of an office they cannot go to a pharmacy in Idaho and buy the product. Midwives have to go through a wholesale distributor which is a struggle for them because they do not have wholesale volume, so wholesale dealers do not want to sell to them.

TESTIMONY:

Bill Silvias, a Treasure Valley pharmacist who works in long-term care, spoke in favor of **H 0006**. He said he would be affected directly by this legislation. He was one of the pharmacists who presented it to the BOP for consideration of the statute change.

Senator Hagedorn asked Mr. Silvias if this was a duplication of current institutional policy to hospice. **Mr. Silvias** said no, this is separate.

Senator Schmidt asked Mr. Johnston how this compares with the work of the Telehealth Task Force regarding rules and statutes. **Mr. Johnston** said it is independent from the Task Force. **H 0006** adds an additional form of communication for taking a verbal order and entering it into the data system to send it to the pharmacy.

MOTION:

Vice Chairman Martin moved to send **H 0006** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion. The motion carried by **voice vote**. Senator Hagedorn will carry the bill on the floor.

H 0007

Mr. Johnston explained the BOP was statutorily mandated to maintain Idaho's Prescription Monitoring Program (PMP), whereby certain data of dispensed CS is collected, collated into patient and prescriber profiles, and made available to authorized users. The two statutory purposes for creating the PMP were assisting in identifying illegal activity related to the dispensing of CS and transmission of prescription drug orders, and assisting the BOP in providing information to patients, practitioners and pharmacists to help avoid inappropriate use of CS. **Mr. Johnston** said there was no statutory allowance to release PMP data pursuant to subpoenas for civil law suits, such as divorce and child custody cases. In Idaho, attorneys have subpoena power and often the BOP receives phishing subpoenas from one spouse's attorney wanting the other spouse's private health information (PHI). The BOP continually uses its resources to have contract attorneys at the Attorney General's office pen denials for such requests. The BOP realizes there may be valid reasons why PMP data might be pertinent to a civil case. **H 0007** would require that a presiding judge issue a subpoena for PMP data and would clearly codify that a subpoena from an attorney was not a valid method to obtain PMP data. He said the BOP checked with the administrative director of the courts who responded that the courts had no issue with the bill. **Mr. Johnston** urged the Committee to send **H 0007** to the floor with a do pass recommendation.

MOTION:

Senator Hagedorn moved to send **H 0007** to the floor with a **do pass** recommendation. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**. Senator Hagedorn will carry the bill on the floor.

H 0008

Mr. Johnston explained Congress passed the Drug Quality and Security Act in November 2013. Provisions of this act become effective at various dates over the next decade, so he expects to present future bills on this topic. The first provision became effective on January 1, 2015, and preempted states from tracking the distribution of prescription drugs. Due to this preemption, **H 0008** strikes several definitions and lines of the Idaho Pharmacy Act (IPA) and the Idaho Wholesale Drug Distribution Act (IWDDA) that require and regulate pedigrees, which are transaction information statements that accompany certain drug distributions. This project grew past its initial focus as the BOP also wanted to address the issue of grey wholesaling as addressed in a congressional report and a National Association of Boards of Pharmacy (NABP) task force white paper. Additionally, Congress passed the Ryan Haight Act, which placed certain duties upon wholesale distributors of CS, which the BOP also desires to enforce for public safety.

Mr. Johnston reported the IWDDA was very needed, considering the immense amount of counterfeit, dangerous drugs that exist in other countries. He said Idaho was progressive in passing the IWDDA in 2007, but perhaps premature in terms of language development as it had been altered in some fashion by the Idaho Legislature nearly every year since its inception. **H 0008** addresses many outstanding issues that still remain within the IWDDA. **Mr. Johnston** reported the BOP worked with the Healthcare Distribution Management Association (HDMA), the national association for wholesalers, who applauded the BOP for addressing many outstanding issues before other states had. He was not aware of any opposition to the bill, which was prompted by federal preemptions. He urged the Committee to send **H 0008** to the floor with a do pass recommendation.

Senator Schmidt asked about Idaho Code § 54-1734, possession of legend drugs, and how midwives fit into it as legally possessing drugs. **Mr. Johnston** said midwives were not included, and they should have been listed in § 54-1734. **Senator Schmidt** commented that Mr. Johnston would probably be back to do that next year.

Senator Nuxoll stated she was having difficulty going along with **H 0008** because of the amount of federal government preemption of law.

MOTION:

Senator Schmidt moved to send **H 0008** to the floor with a **do pass** recommendation. **Senator Lacey** seconded the motion. The motion carried by **voice vote**. **Senator Nuxoll** requested that she be recorded as voting nay. Senator Schmidt will carry the bill on the floor.

**FURTHER
DISCUSSION:**

Senator Hagedorn asked Senator Schmidt if **H 0008** should be sent to the 14th Order for amendment to include the midwives this year rather than wait for a new bill next year. **Senator Schmidt** said it should be a project for next year due to its complexity.

H 0009

Mr. Johnston explained Idaho Code § 37-2702(d) says that if any substance was designated, rescheduled, or deleted as a CS under federal law and notice was given to the BOP, the BOP should similarly control the substance under the act after the expiration of 30 days. He said § 37-2714 mandated that the BOP update Idaho's schedules of CS annually. The proposal accomplished the BOP's statutory requirement to update, as the DEA had during the past year. He also said the substances were already controlled in Idaho; this bill would put into print what was already law. **Mr. Johnston** urged the Committee to send **H 0009** to the floor with a do pass recommendation.

Senator Johnson (Lodge) asked if the BOP had to accept federal regulations or if they were just a guideline. **Mr. Johnston** said the federal government took a lot into account to change a drug's schedule. In most cases, the BOP wanted a drug to be controlled in Idaho if the federal studies said it should be controlled. He was not aware of a product scheduled federally and not scheduled in Idaho. Ninety-nine percent of the thousands of CS drugs written into Idaho Code are exactly the same as the federal schedule, but Idaho has scheduled approximately 1 percent more. Some examples are illicit drugs like bath salts, spice and what's commonly known as the date rape drug. He said the BOP takes its independent authority to schedule seriously.

Senator Nuxoll asked if the BOP had ever rejected something the federal government had deemed necessary to follow. **Mr. Johnston** said, during his years as Executive Director, the BOP had not rejected anything on the federal schedule, but the BOP had scheduled more stringently than the federal government.

MOTION: **Vice Chairman Martin** moved to send **H 0009** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**. Vice Chairman Martin will carry the bill on the floor.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:12 p.m.

Senator Heider
Chairman

Erin Denker
Secretary

Paula Tonkin
Assistant Secretary

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, February 18, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Presentation	State diet manual, CMS diet rule, reporting harm, Patient Centered Medical Home initiative, and working with H&W on the SHIP.	Megan R Williams MDA, RDN, LD, CDE (President-elect 2015-2016) Samantha A. Ramsay PhD, RDN, LD (President 2014-2015) The Idaho Academy of Nutrition and Dietetics
<u>H25</u>	RELATING TO PHYSICAL THERAPY	Brian White Chairman Board of Physical Therapy Licensure Chairman
<u>H23</u>	RELATING TO MASSAGE THERAPY	Roger Hales Administrative Attorney
<u>H24</u>	RELATING TO OCCUPATIONAL THERAPY	Roger Hales Administrative Attorney

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider	Sen Tippetts
Vice Chairman Martin	Sen Lee
Sen Johnson(Lodge)	Sen Schmidt
Sen Nuxoll	Sen Lacey
Sen Hagedorn	

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 18, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Nuxoll, Hagedorn, Tippetts, Lee and Schmidt

ABSENT/ EXCUSED: Senators Lodge and Lacey

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:00 p.m. and welcomed all in attendance.

PRESENTATION: **Megan R. Williams**, MDA, RDN, LD, CDE, licensed registered dietitian nutritionist and certified diabetes educator, introduced herself and Dr. Samantha A. Ramsay, who took the podium.

Dr. Samantha A. Ramsay, PhD., RDN, LD, President of the Idaho Academy of Nutrition and Dietetics (Academy), thanked the Committee for its support of the Senate Concurrent Resolution passed in 2013 which sanction the credentials of registered dietetic nurses (RDNs) and presented an update on the Academy (see attachment 1). This resolution has made it possible for RDNs to have their skills recognized as a valuable part of disease and treatment prevention. She said there are 600 licensed RDNs and dietetic students in all 35 legislative districts of Idaho. The Academy has been very successful with its focus on the wellbeing of Idahoans.

Ms. Williams took the podium to describe the results of a recent study which emphasized the importance of proper medication and lifestyle counseling in combating chronic diseases such as diabetes and obesity. She said RDNs are in a unique position to manage the prevention and treatment of those diseases.

Dr. Ramsay concluded the presentation with an update on the Center for Medicaid/Medicare Services' (CMS) ruling. This ruling allows for RDNs to order diet and lab tests independently. She said the Academy has created a diet manual for use in health care facilities and is working closely with the Idaho Board of Medicine to ensure regulatory compliance.

Vice Chairman Martin asked Ms. Williams about educational requirements.

Ms. Williams said the requirements include a four-year bachelor's degree in an accredited program, admittance to an internship through the national governing agency, and passing a national standardized exam. **Ms. Williams** added that a master's requirement will be mandated by 2024. **Vice Chairman Martin** also asked about salary levels. **Dr. Ramsay** said salaries range from \$30,000 to \$90,000, depending on location and nature of work.

Senator Nuxoll asked what the CMS rule is. **Dr. Ramsay** stated that it is a rule through the Centers for Medicare/Medicaid Services, which is the federal governing agency on to track medical care. She said she would provide the information Senator Nuxoll requested.

Senator Hagedorn asked how hospitals and doctors would pay for RDNs' services and if models for payment had been established. **Dr. Ramsay** said revenue source is a challenge, but some models, such as charging a monthly fee, are in place.

Chairman Heider thanked Ms. Williams and Dr. Ramsay for their presentations.

H 25

Relating to Physical Therapy: Brian White, Chairman of the Board of Physical Therapy (Board), stated **H 25** would add an exemption for individuals to practice physical therapy in the State. This exemption would allow those licensed in another jurisdiction to travel to Idaho and provide physical therapy for a performing arts company visiting Idaho or for an athletic event, team or athlete competing in Idaho. This bill would allow therapists to practice in the State for no less than 60 days without consequence (see attachment two).

Senator Schmidt asked if the Board would be cataloguing who would qualify for this exemption. **Mr. White** answered that no mechanism had yet been developed for such monitoring. A discussion was held relative to the 60-day limit and **Mr. White** explained the details. **Senator Tippetts** expressed concern that an out-of-state licensed therapist might set up an office in Idaho. **Mr. Hales**, an administrative attorney, was asked to respond. **Mr. Hales** replied that the statute would not allow that scenario.

Senator Hagedorn asked if there was a code defining more closely the organizations that would exempt their therapists. **Mr. White** said he was not aware of a code to define those organizations. **Mr. Hales** agreed there is not a code to define these organizations but said the Board is attempting to recognize such occurrences under limited circumstances. A discussion ensued on language and time frame.

MOTION:

Senator Tippetts moved to send **H 25** to the floor with a **do pass** recommendation. **Senator Martin** seconded the motion. The motion carried by **voice vote**. Vice Chairman Martin will carry **H 25** on the floor.

H 23

Relating to Massage Therapy: Roger Hales, administrative attorney for the Massage Therapy Board, presented **H 23**. The legislation would allow those licensed in another jurisdiction to travel to Idaho and provide massage therapy for an athletic event, team or athlete competing in Idaho or performing arts companies performing in Idaho for no more than 60 calendar days (see attachment 3). **Mr. Hales** described the bill and said the wording was written by Legislative Services. He said there had been no opposition to the bill after discussion in several meetings.

Senator Schmidt asked if any physical or massage therapists had ever been prosecuted for practicing without a license. **Mr. Hales** stated he was not aware of such an occurrence.

MOTION:

Vice Chairman Martin moved to send **H 23** to the floor with a do pass recommendation. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**. Vice Chairman Martin will carry the bill on the floor.

H 24

Relating to Occupational Therapy: Roger Hales, administrative attorney on behalf of the Idaho Occupational Therapy Licensure Board (Board), presented **H 24**. **Mr. Hales** stated that this bill reduces regulation by eliminating a licensee's obligation to obtain 20 professional development hours every two years for license renewal. He said this change will save licensees both time and money. Professional development education typically assists licensees in their development as a professional, while continuing education addresses a licensee's continued competence to practice. He emphasized licensees would still be required to obtain 20 hours of continuing education every two years under the existing rules (see attachment 4). He said there has been no opposition to the bill.

Senator Tippetts asked the difference between professional development units and continuing education units. **Mr. Hales** explained the difference and said the Board felt the required 20 hours of professional development were unnecessary. He reiterated the continuing education rules will still be required.

MOTION: **Senator Schmidt** moved to send **H 24** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion. The motion carried by **voice vote**. Senator Schmidt will carry **H 24** on the floor.

ADJOURNED: **Chairman Heider** thanked everyone for their attendance and participation. There being no further business, the meeting adjourned at 4:03 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Assistant Secretary



**IDAHO ACADEMY OF
NUTRITION & DIETETICS**
eat right. an affiliate of the
Academy of Nutrition and Dietetics

Mission: The Idaho Academy of Nutrition and Dietetics is the premier source for reliable, objective food and nutrition information in Idaho. We empower the 400 members of Idaho Academy of Nutrition and Dietetics to be the food and nutrition leaders in Idaho.

Vision: Optimize the health of Idahoans through food and nutrition.

Registered Dietitian Nutritionists (RDNs) are the only licensed nutrition professional in Idaho. RDN's are an ideal part of a team providing cost-effective patient centered care to individuals. RDNs are trained to provide Medical Nutrition Therapy (MNT) through a nutrition centered care plan. A nutrition centered care plan focuses on the assessment, nutrition diagnosis, treatment plan, evaluation and monitoring of an individual's progress.

The **Institute of Medicine (IOM)** identifies RDN professionals as the single, identifiable group of health-care professionals with standardized education, clinical training, continuing education and national credentialing requirements necessary to provide and to be directly reimbursed as a provider of nutrition therapy.

RDNs work in a variety of settings

- **Medical-Clinical:** Deliver care in Idaho hospitals, medical clinics, diabetes education programs, skilled nursing and assisted living facilities, cancer care and sports medicine.
- **Education:** Teach and conduct research in Idaho colleges and universities.
- **Public Health:** Deliver programs serving the public such as Women Infants and Children (WIC) programs, state and local public health, school nutrition programs and Cooperative Extension.
- **Business:** Serve as nutrition experts to food and pharmaceutical companies.
- **Health Promotion and Disease Prevention¹:**
 - Provide **weight management counseling** and behavior change to reduce **overweight and obesity**.
 - Of Idaho adults over 18 years of age, **62 percent** are overweight or obese.
 - Provide **health and wellness education** to prevent **chronic disease** and disease complications such as for **diabetes and cardiovascular disease**.
 - **9.4 percent** of Idaho adults over 18 have diabetes; **6.8 percent** have pre-diabetes.
 - Promote healthy **food and nutrition** messages in Idaho communities such as eating more fruits and vegetables, reducing salt intake and choosing leaner foods to reduce high blood pressure and cholesterol.
 - **82.5 percent** of Idaho adults do not eat the daily recommended five servings of fruits and vegetables
 - **29 percent** of Idaho adults have high blood pressure; **39 percent** have high cholesterol.

Education, experience and on-going nutrition training requirements make the RDN the preferred nutrition professional in Idaho.

¹ Idaho Department of Health and Welfare, Division of Public Health. 2012 Idaho Behavioral Risk Factor Surveillance System. Health in Idaho: A State Profile 2012.

Talking Points
House Bill 25

Idaho Board of Physical Therapy

- House Bill 25 is brought on behalf of the Idaho Board of Physical Therapy.
- This Bill adds an exemption to the Act that regulates physical therapy.
- It would allow those licensed in another jurisdiction to travel to Idaho and provide physical therapy for a performing arts company visiting Idaho or for an athletic event, team or athlete competing in Idaho.
- No concern that this exemption will jeopardize public health. Limited to 60 days a year.
- Could involve assisting ballet or dance companies traveling through Idaho or teams that compete against the Idaho Steelheads hockey team, Boise Hawks baseball team, or athletes that compete in various competitions in Idaho.
- There is No opposition to this bill.

Talking Points
House Bill 23

Idaho Board of Massage Therapy

- House Bill 23 is brought on behalf of the Idaho Board of Massage Therapy.
- This Bill adds an exemption to the Act that regulates massage therapy.
- It would allow those licensed in another jurisdiction to travel to Idaho and provide massage therapy for an athletic event, team or athlete competing in Idaho and for performing arts companies performing in Idaho.
- No concern that this exemption will jeopardize public health. Limited to 60 days a year.
- Could involve teams that compete against the Idaho Steelheads hockey team, Boise Hawks baseball team, or athletes that compete in various competitions in Idaho.
- There is No opposition to this bill.

**Talking Points
House Bill 24**

Idaho Occupational Therapy Licensure Board

- House Bill 24 is brought on behalf of the Idaho Occupational Therapy Licensure Board which regulates the practice of occupational therapy in Idaho.
- This Bill reduces regulation.
- It eliminates a licensee's obligation to obtain 10 professional development hours every two years for license renewal. This change will save licensees time and money.
- Professional Development education typically assists licensees in their development as a professional as opposed to continuing education which addresses a licensee's continued competence to practice.
- Licensees will still need to obtain 20 hours of continuing education every 2 years under existing laws/rules.
- There is No opposition to this Bill.

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, February 19, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for January 20, 2015 Approval of the Minutes for February 4, 2015	Senator Hagedorn Senator Martin
Gubernatorial Appointment Hearing	Reappointment of Darrell Kerby to The State Board of Health and Welfare	Darrell Kerby
Gubernatorial Appointment Hearing	Reappointment of Stephen Weeg to The State Board of Health and Welfare	Stephen Weeg
Gubernatorial Appointment Hearing	Reappointment of Richard T. Roberge to The State Board of Health and Welfare	Richard T. Roberge

If you have written testimony, please provide a copy of it to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 19, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Lacey

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) meeting to order at 3:04 p.m.

Chairman Heider thanked outgoing page Cameron Floyd for his service and welcomed the Committee's new page, Christopher (Chris) Miller. Mr. Floyd thanked the Committee for its patience and described his plans for the future.

RS 23566C1 **Chairman Heider** asked the Committee for unanimous consent to send **RS 23566C1** to the Judiciary and Rules Committee for printing. He explained the word "surgical" had been added just before the word "abortion" in the Statement of Purpose. The motion carried by **voice vote**.

RS 23655 **Vice Chairman Martin** asked for unanimous consent to send **RS 23655** to the Judiciary and Rules Committee for printing. There were no objections.

MINUTES APPROVAL: **Senator Hagedorn** moved to approve the Minutes of January 20, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**

Vice Chairman Martin moved to approve the Minutes of February 4, 2015. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**

GUBERNATORIAL APPOINTMENT HEARING: **Chairman Heider** welcomed Darrell Kerby to the podium to review his background and answer questions relative to his reappointment to the State Board of Health and Welfare (Board).

Mr. Kerby, from Bonners Ferry, Idaho, summarized his professional background and noted that he has served two terms on the Board. He has also served 28 years as an elected official in other capacities. He said he is a real estate agent and independent insurance agent by profession and continues to monitor the Affordable Care Act (ACA) and its implementation in Idaho.

Senator Tippetts asked if the Board has an impact on how the health exchange contract is administered. **Mr. Kerby** said the Board helps guide and advise only and is kept up to date on the issues.

Chairman Heider noted that Senator Keough will carry the appointment on the floor when the decision is made.

**GUBERNATORIAL
APPOINTMENT
HEARING:**

Mr. Stephen Weeg reviewed his background relative to his reappointment to the State Board of Health and Welfare. Now retired, he has chaired Idaho's health insurance exchange since its inception. He is also on the Health and Welfare Board and the Portneuf Health Care Foundation and Medical Center Boards. His career spans more than 40 years in health and human services, and he has been involved in the Governor's health care summit and select committee on health care. He said he is a Pocatello native and feels he brings a depth of experience to the Board.

Chairman Heider asked for Mr. Weeg's opinion on the successes of Idaho's insurance exchange and the number of insured individuals so far. **Mr. Weeg** said the exchange has made a huge difference to formerly uninsured individuals. Because of the recent cutoff date, he said the number of insured participants is still being tallied.

Vice Chairman Martin asked about the cost of Idaho's health insurance exchange compared with other states. **Mr. Weeg** said Idaho has the lowest number of paid staff of any state-based exchange; development costs are lower than other states.

Senator Nuxoll asked about number of staff. **Mr. Weeg** said there are 14 paid staff. **Senator Schmidt** ask Mr. Weeg to elaborate further on his experience and to state his party affiliation. **Mr. Weeg** restated his experience in more depth and said he is a Democrat.

Senator Hagedorn asked Mr. Weeg's opinion on Health and Welfare Department's biggest obstacles. **Mr. Weeg** said a major obstacle is the dearth of minimum wage jobs which results in the need for more food stamps, Medicaid assistance and other services. He said the answer is a better economy, better education and higher income.

**GUBERNATORIAL
APPOINTMENT
HEARING:**

Dr. Richard Roberge, Caldwell, Idaho, summarized his background relative to his reappointment to the State Board of the Health and Welfare. He explained that this is his fourth nomination to the Board. He is a retired obstetrician.

Senator Schmidt asked about his party affiliation. **Dr. Roberge** said he is an Independent. **Vice Chairman Martin** asked him to expand further on his experience. **Dr. Roberge** elaborated on his background as an obstetrician and reviewed his service on various boards.

Chairman Heider said votes on all three gubernatorial appointments will be held February 23, 2015.

Chairman Heider welcomed former Senator Joyce Broadsword to the podium. **Senator Broadsword** spoke fondly of her years as Senator and her service on the Committee. She said she is now an employee of Idaho's Health and Welfare Department, a position she enjoys very much.

ADJOURNED:

There being no further business, **Chairman Heider** adjourned the meeting at 3:38 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant Secretary

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, February 23, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Gubernatorial Appointment Consideration	Reappointment of Darrell Kerby	Darrell Kerby
Gubernatorial Appointment Consideration	Reappointment of Stephen Weeg	Stephen Weeg
Gubernatorial Appointment Consideration	Reappointment of Richard T. Roberge	Richard T. Roberge
<u>S1060</u>	RELATING TO PSYCHOLOGISTS	Kris Ellis Idaho Psychological Association

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Johnson(Lodge)
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, February 23, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippets, Lee, Schmidt, Lacey

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:03 p.m. with a quorum present.

GUBERNATORIAL APPOINTMENT: **Senator Martin** moved to send the gubernatorial appointment of Darrell Kerby to the State Board of Health and Welfare to the floor with the recommendation that he be confirmed by the Senate. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

GUBERNATORIAL APPOINTMENT: **Senator Lacey** moved to send the gubernatorial appointment of Stephen Weeg to the State Board of Health and Welfare to the floor with the recommendation that he be confirmed by the Senate. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

GUBERNATORIAL APPOINTMENT: **Senator Schmidt** moved to send the gubernatorial appointment of Richard Roberge to the State Board of Health and Welfare to the floor with the recommendation that he be confirmed by the Senate. **Senator Lodge** seconded the motion. The motion carried by **voice vote**.

S 1060: **Relating to psychologists; Kris Ellis**, Eiguren, Fisher and Ellis, representing the Idaho Psychological Association (IPA) explained **S 1060** would grant clinical psychologists the ability to add prescriptive authority to their practice after receiving a masters in psychopharmacology and with the collaboration of a medical provider. She said the bill supports Idaho's shift towards a collaborative care health care system.

Senator Tippets stated he had a potential conflict of interest pursuant to Senate Rule 39 (H). He asked Ms. Ellis to explain the meaning behind the wording "to be recognized in the diagnose, management and treatment of mental disorders." **Ms. Ellis** said she would defer the answer to Mr. Leroy or another more qualified individual. **Senator Schmidt** wanted clarification on the collaboration requirement between the psychologist and a medical professional. **Ms. Ellis** stated an agreement was not reached with the Idaho Medical Association (IMA) prior to the introduction of **S 1060**. She said an advisory panel would develop the process of collaboration in rule.

Senator Hagedorn asked which federal entities and states had implemented this process. **Ms. Ellis** stated the U.S. military, Indian Health Services, U.S. Health Services and several states currently were granting prescription rights to Ph.D. psychologists.

TESTIMONY:

Dr. Page Haviland, licensed psychologist, stated granting prescription rights would increase the quality of care to patients, because currently nonsuicidal patients must wait one to two months to be seen by a psychiatrist or psychiatrically trained physician assistant. She said patients would benefit from more responsive and affordable mental health care by eliminating duplicate office visits and an earlier introduction of necessary medications.

Anne Trotter, St. Luke's Outpatient Services; the Twin Falls Emergency Room, expressed their support for **S 1060** as well as her own support. She said the lack of sufficient access to prescribing mental health providers created a difficulty in providing patients with a timely, cost effective means of receiving medication. **Ms. Trotter** expressed the importance of patients maintaining their mental health medication regiment to reduce or prevent costly emergency room visits.

Molly Steckel, IMA, stated the IMA was not able to reach an agreement on a collaborative process with the IPA, because the IMA, as well as member physicians and the Idaho Psychiatric Association, felt **S 1060** was not in the best interest of the patient. She said the primary concern was psychologists lacked the general medical training necessary to understand all the complications and issues arising from prescribing medications. She expressed that medical professionals felt enhancing quality and speed of mental health care was important, however, the method was not **S 1060**.

Senator Tippetts asked how the education requirement in the bill compared with the psychopharmacological training of a psychiatrist. **Ms. Steckel** said as it was explained to her the psychopharmacological training involved in a masters degree did not include the advanced medical training of nursing and other prescribing medical professionals. **Senator Tippetts** inquired if the collaboration portion of the bill was enough to address the specific concern about medical training. **Ms. Steckel** answered additional training and collaboration were included to prevent the consulting medical professionals from becoming a supervisor to someone outside their practice and to reduce adverse risk to the patient by adding additional medication to their existing regiment.

Chairman Heider excused Senator Lodge from the meeting.

Ben Seymour, addiction professional, founder and CEO of Ashwood Recovery, Boise, stated properly trained psychologists being granted prescriptive authority was the right move to make as health care moves toward a more holistic approach. **Vice Chairman Martin** asked Mr. Seymour if this bill was passed, would he be able to write prescriptions. **Mr. Seymour** responded no, because he was not a psychologist.

Kent Kunz, Director of Government Relations, Idaho State University, stated the college was neither for or against the bill. He shared Paul Cady's letter stating the mission of the College of Pharmacy at Idaho State University. The letter included a commitment to providing psychopharmacological and pharmacology courses within the psychology department with the passage of **S 1060**.

Dr. Gary Payne, psychologist, Ph.D., retired, discussed the challenge of adequate medication management for mental health patients due to high patient to prescriber ratios which resulted in long scheduling times and short follow up visits. This problem was not limited to the private sector and included government and community based organizations. He said by allowing psychologists to gain prescription authority, the mental health care access problem can be addressed without an expansion of government.

Senator Nuxoll asked if online education in the field of psychopharmacology was a problem. **Dr. Payne** stated this masters program was not best served as a strictly online based curriculum. **Senator Nuxoll** wanted to know if the psychologists' rates would increase with the additional training. **Dr. Payne** said a rate increase would be up to the individual practitioner. **Senator Schmidt** asked Dr. Payne his opinion on why access to mental health care was so limited in Idaho. **Dr. Payne** said one reason was the lack of a medical school. Adequate advocacy for preventative versus a reactive method of treatment was difficult to garner because of the stigma attached to mental health issues.

Dr. Ron Larson, psychiatrist, Veterans Affairs (VA), stated the ongoing medical student training and psychiatric residency programs through the VA and telepsychiatry in the rural areas were helping to alleviate the access to care issue. He said the similar medical training received by psychiatrists and primary care physicians allowed for a well managed integration of care in handling mental health issues. The risk of having a non-medically trained professional write prescriptions was borne by the patient with an increased possibility of drug interactions, improperly identified side effects, and misdiagnosis of symptoms. **Senator Hagedorn** asked why Dr. Larson was opposed to the bill when the VA's allowance of prescriptive authority to psychologists did not create any negative effects. **Dr. Larson** said the attempt was not proven to work for solving the problem of adequate access to care.

Senator Tippetts asked how the scope of training received by a mastered psychologist and Ph.D. psychiatrist differed. **Dr. Larson** stated the difference was vast. The lack of background medical training made the risk to the patient too great to be supportive of the bill.

Dr. Justin Bailey family medicine faculty, associate professor of family medicine, University of Washington; family medicine residency, University of Idaho, said the difference in the medical training psychiatrists received versus a 200 hour masters program requirement for prescribing psychologists was a concern with the bill. **Dr. Bailey** added prescriptive authority for psychologists will not help the problem of access to care in rural communities as the concentration of mental health care providers in Idaho was currently centered in larger population areas.

Dr. Marlin Hoover, prescribing psychologist; faculty member, family medicine resident program, said his job was to teach both psychologists and family physicians about integrated care. He provided an overview on how collaboration worked between the two groups. The primary care doctor is called upon after observation that the patient may benefit from psychotropic medication. The physician is the one who authorizes medical clearance for the patient, not the psychologist. This collaboration, in conjunction with the additional training requirements, has made New Mexico's law successful. **Senator Tippetts** asked how long psychologists had been allowed prescriptive authority in New Mexico. **Dr. Hoover** stated he believed it was since 2004, and the current number of licensed prescribing psychologists was 38. **Senator Tippetts** asked Dr. Hoover to provide his experience with the program. **Dr. Hoover** stated, to his knowledge, there had not been any adverse effects to patients.

Senator Lee wanted to know if New Mexico required the contact between a psychologist and a primary care physician and if **S 1060** has similar requirements. **Dr. Hoover** said New Mexico's language mandates collaboration between the psychologist and a medical professional; **S 1060** had similar language. **Senator Nuxoll** asked if the education requirements for a psychologist were enough, adequate or the same as other medical professionals. **Dr. Hoover** answered the training was adequate to work in collaboration with a medical professional.

Dr. Julie Foote, endocrinologist, told the Committee her practice cared for the endocrine problems of severely mentally ill patients. She said she opposed this bill because 68 percent of mentally ill patients have preexisting and/or coexisting conditions and the risk for undesired or unintended consequences was great. She expressed concern over the terminology "shall collaborate" because it would be difficult to enforce through legislative rule. **Senator Hagedorn** asked Dr. Foote if there was a current issue of prescribing contraindicated medicines by medical professionals. **Dr. Foote** replied her patients are referred from physicians and psychiatrists who acknowledged the preexisting medical issues that would be complicated from psychotropic medications. The issue wasn't with inadequate medical training, it was the underlying complications which required specific, focused care by all the prescribing medical professionals.

Dr. Michael Tilus, prescribing medical psychologist, United States Public Health Services, Crow Nation; President, American Psychological Association, Division 55, stated in the previous 20 years there have been no reported adverse effects caused by prescribing psychologists. He urged the Committee to approve **S 1060**.

Dr. Jeralyn Jones, psychiatrist, Program Director, Idaho track for University of Washington, Psychiatry Residency, said she was opposed to the bill because the SHIP program that had been recently implemented was designed to meet the need for whole health integration between physicians, psychiatrists, and psychologists.

Dr. Sandra Firth, psychologist, Mountain Home, said rural access for mental health care was a serious issue. She stated her belief that collaborative mental health care could be accomplished between the different professions.

David Leroy, Esquire, IPA, stated he was the writer of **S 1060** and the coordinating rules. **Mr. Leroy** expounded on how **S 1060** was rooted in many years of successful history in New Mexico and other states and federal entities. He said the training requirements for psychologists, the narrow formulary, and the collaboration with a medical professional presented no risk to the patient. **Senator Schmidt** asked Mr. Leroy how the enforcement of "shall collaborate" would be monitored. **Mr. Leroy** said he did not think the standard of collaboration would be ambiguous or incomplete; the advisory panel would establish the expectations of collaboration.

Senator Tippetts asked about the intent of the language regarding medication being "recognized." **Mr. Leroy** said for the medication to be recognized it would have to be deemed useful for the treatment of mental illness as well as listed on the formulary available to prescriptive psychologists approved by the advisory panel. **Senator Tippetts** requested elaboration on the language of "other procedures directly related thereto" in regards to the practice of psychology. **Mr. Leroy** stated the general language was written to be broad enough to accommodate the various boards involved, legislative regulation, and both current and future considerations.

Senator Tippetts wondered why the bill must be broadened to include "other procedures directly related thereto." **Mr. Leroy** stated the terminology was left intentionally broad to allow for statutory direction after receiving guidance from the Board of Pharmacy, Board of Medicine, and Board of Psychologists Examiners. **Senator Tippetts** asked why there was a need to establish an advisory panel versus adding a member or two to the existing board. **Mr. Leroy** said the advisory panel should have a narrow emphasis while allowing for interaction from other medical boards, rather than the broader scope of the IPA board. **Senator Hagedorn** asked how **S 1060** addressed the recruitment of out of state prescribing psychologists. **Mr. Leroy** said the intent was to create a unified approach to recruitment of both new and current prescribing psychologists.

Senator Lacey asked if the collaboration was to take place before or after the prescription was issued. **Mr. Leroy** said the regulation established by the board would decide on the occurrence of the collaboration but expected the regulation to look similar to New Mexico's law.

MOTION:

Senator Nuxoll moved to send **S 1060** to the floor with a **do pass** recommendation. **Vice Chairman Martin** seconded the motion.

Vice Chairman Martin said **S 1060** was written well enough to establish adequate and appropriate guidance for the implementation of allowing psychologists prescription authority.

Senator Schmidt said he was troubled by the bill's focus on collaboration with medical professionals, yet collaboration prior to the introduction of this bill did not happen.

Senator Tippetts stated **S 1060** had some unanswered questions, yet the testimony given by practitioners in New Mexico gave a clear picture of the safety and effectiveness of the program.

Senator Lee said there seemed to be a difficulty in creating collaboration that did not include an adversarial or supervisory role for the medical professional; she was opposed to the bill.

Senator Nuxoll stated the need for access to mental health care was great in Idaho and the testimony from New Mexico was encouraging about the safety of granting prescriptive authority to psychologists.

VOTE:

Chairman Heider called for a roll call vote. **Senators Martin, Nuxoll, Hagedorn, Tippetts** and **Chairman Heider** voted **aye**. **Senators Lee, Schmidt** and **Lacey** voted **nay**. The motion carried.

CONVENED:

There being no further business, **Chairman Heider** adjourned the meeting at 4:12 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jenny Smith
Assistant Secretary

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, February 24, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for January 26, 2015	Senator Schmidt
	Approval of the Minutes for January 28, 2015	Senator Tippetts
	Approval of the Minutes for January 29, 2015	Senator Lee
Gubernatorial Appointment Hearing	John McCreedy of Boise, Idaho, was reappointed to the Board of Environmental Quality	John McCreedy
Gubernatorial Appointment Hearing	Curt Fransen of Garden City, Idaho, was reappointed to Director of the Department of Environmental Quality	Curt Fransen
Gubernatorial Appointment Hearing	Kermit Kiebert of Hope, Idaho, was reappointed to the Board of Environmental Quality	Kermit Kiebert
<u>S1101</u>	RELATING TO INDIGENT SICK	Rep. Trujillo Senator Schmidt

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, February 24, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Hagedorn, Tippets, Lee, Schmidt and Jordan

ABSENT/EXCUSED: Senator Nuxoll

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** welcomed everyone in attendance and convened the meeting at 3:00 p.m.

MINUTES APPROVAL: **Senator Schmidt** moved to approve the Minutes of January 26, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Tippets** moved to approve the Minutes of January 28, 2015. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Lee** moved to approve the Minutes of January 29, 2015. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

GUBERNATORIAL APPOINTMENT: The reappointment of John McCreedy of Boise, Idaho, as a member of the Board of Environmental Quality (Board), to serve a term commencing July 1, 2014 and expiring on July 1, 2018.

Mr. McCreedy stated that he had been a member of the Board for the last three years and was familiar with most federal and state environmental laws and the authorization process used by the DEQ. He felt that his greatest strengths were on the administrative law side, rule approval process, and review of DEQ decisions. He indicated he was familiar with the Board's agenda for the next few years and was looking forward to serving the State of Idaho.

Chairman Heider asked for questions from the Committee.

Senator Tippets asked when Mr. McCreedy was first appointed to the Board and how he felt about his past experience. **Mr. McCreedy** said he was originally appointed to the Board in either 2011 or 2012. He said that he had worked under two directors and found them both to be very prepared. Their staff had done an outstanding job. Environmental regulations are very complex, and this agency did a good job in handling relevant issues.

Senator Schmidt asked how many members of a particular political party had been appointed to the Board. **Mr. McCreedy** responded that he was part of the Independent Party. He recognized that doesn't fit under the definition of a political party, and he stated that he had consistently voted both sides of the ticket.

Senator Hagedorn asked why Mr. McCreedy was a member of the Washington State Bar as well as the Idaho State Bar. **Mr. McCreedy** said that he first applied to the Washington State Bar when he was representing Goodman Oil Company. Mr. McCreedy had been advised not to practice law in his current position.

MOTION: **Senator Tippetts** moved to send the gubernatorial reappointment of John McCreedy as a member of the Board of Environmental Quality to the floor with the recommendation that he be confirmed by the Senate. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

GUBERNATORIAL APPOINTMENT: The appointment of Curt Fransen of Garden City, Idaho, as Director of the Department of Environmental Quality (DEQ), to serve a term commencing January 5, 2015 and expiring on January 7, 2019.

Mr. Fransen said it was his priority to maintain and enhance the progress made by Director Hardesty during her tenure. He found the DEQ's structure, staff and policies to be very sound and didn't see any need to make any personnel or organizational changes. He saw three challenges that the DEQ faces. The first issue is the fish consumption survey and issues related to it. Data from the survey will be available in the spring after a two year process. The second issue is HB 406 permitting system for discharges to surface waters throughout the State. HB 406 directed the DEQ to submit application by September 2016. To meet that deadline, they need to complete rulemaking by this summer for presentation to the Board in the fall, and have review and approval by the Legislature in the 2016 Session. Funding a program of this size is a big challenge. The third concern is there are current and pending changes being made by the EPA to health based national ambient air quality standards. Standards are reviewed and updated every five years by the EPA. The State is required to develop, submit and implement an EPA approved plan to meet the standards and bring the problem areas back into compliance. Monitoring and planning efforts to address these issues are significant. If EPA rules regarding existing power plants are approved, it will require a major work load for DEQ to develop a state plan to bring down emissions 30 percent by the year 2030.

Chairman Heider asked for questions.

Senator Hagedorn asked what would happen if Idaho went into a position of nonattainment concerning the PM 2.5 standard and did not take the appropriate steps to correct it. **Mr. Fransen** stated that if the State didn't take care of it, the EPA would use whatever measures they used in other parts of the country.

MOTION: **Senator Lee** moved to send the gubernatorial appointment of Curt Fransen as Director of the Department of Environmental Quality to the floor with the recommendation that he be confirmed by the Senate. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

GUBERNATORIAL APPOINTMENT: The reappointment of Kermit Kiebert, of Hope, Idaho, to the Board of Environmental Quality, to serve a term commencing July 1, 2014 and expiring on July 1, 2018.

Mr. Kiebert began his comments by stating that in 2006 Jim Risch asked him to help on the board of the DEQ. He indicated it has been a very good experience and a great staff to work with. One of his strengths is in the area of collaborative rulemaking and how effective it is making their organization.

Chairman Heider asked for questions.

Senator Schmidt asked Mr. Kiebert about his party affiliation. **Mr. Kiebert** indicated that he is a very fiscally conservative Democrat.

MOTION: **Vice Chairman Martin** moved to send the gubernatorial reappointment of Kermit Kiebert to the Board of Environmental Quality to the floor with the recommendation that he be confirmed by the Senate. **Senator Tippetts** seconded the motion. The motion carried by **voice vote**.

Relating to Indigent Sick: Senator Schmidt and Representative Trujillo worked together to present **S 1101**. **Senator Schmidt** turned the time to Representative Trujillo for presentation of this legislation. **Representative Trujillo** began her presentation with the definition of "medically indigent" as "any person who is in need of necessary medical services and who, if an adult, together with his or her spouse, or whose parents or guardian if a minor or dependent, does not have income and other resources available to him from whatever source sufficient to pay for necessary medical services." This is not related to poverty. It is based on ability to pay. High medical bills outweigh income. She continued by describing the legislative progression of the Catastrophic Cost Health Care Program. It is to be used as a last resort.

Representative Trujillo then discussed the transformation of the CAT Fund and indicated that in 1996 the definition of necessary medical services was added. A provision to allow for coverage of ongoing care, pending surgeries, chronic treatment and other non emergent services was included. She stated that it is the policy of the State that every citizen shall be encouraged to purchase his or her own medical insurance with coverage sufficient to prevent them from needing to request assistance and that the County Medical Indigent Program and the Catastrophic Health Care Cost Program are to be used as a last resort.

Representative Trujillo discussed the 2014 federal mandate requiring everyone to purchase insurance and the eligibility requirements for enrollment periods. Certain life changes, called qualifying life events, may allow an individual to enroll in coverage outside of open enrollment. A question was asked whether the State and local taxpayers should be responsible to pay for individuals' medical bills when they have the option of purchasing their own health insurance. Predictable impacts and savings to taxpayers were also presented (see attachment 1).

A very brief explanation of this legislation is anyone who is at 100 percent of the poverty level would automatically be covered. Anyone between the 100-138 percent of poverty level would be looked at on a case-by-case basis. Anyone above 138 percent would not be covered through the Catastrophic Fund.

Representative Trujillo asked that **S 1101** be sent to the floor with a **do pass** recommendation.

Senator Schmidt indicated that he wore two hats in his role on the Committee. One as a Legislator and the other as a member of the State CAT Board (Board). As a Legislator, he asked the Committee to send this bill to print. He stated that as a Board member, he could not support or oppose this bill. The Board is a state entity, and that is not their role. The Board feels that determining eligibility for catastrophic health care payment is what they do each month. Catastrophic coverage is not insurance, it is a payment plan. In order for people to qualify as indigent, they must be determined as such by the county commissioners. If the need is above \$11,000, they must apply to the state fund. In the last year and a half, the CAT Fund expenses have gone down because people are enrolling in insurance. The enactment of this legislation is March 1, 2016 which gives Idaho citizens time to enroll in insurance programs.

Senator Tippetts had concerns about the language when the bill refers to being "unable" to purchase insurance and what exactly that means. Considerable discussion was held regarding this issue. **Senator Schmidt** responded that occurs when someone has a qualifying event and chooses not to purchase insurance at that time. He reiterated that indigency is determined at the time of the incident. Insurance coverage eligibility is determined under an enrollment period. If one applies for indigency and could have enrolled in insurance either in an enrollment period or a qualifying event and chose not to, then one would not be considered indigent. **Senator Tippetts** asked about the circumstances regarding what it means to be "unable" to purchase insurance if a person did not have the funds to do it. He suggested that the meaning would be more clear if it said that a person chose not to purchase the insurance. **Senator Schmidt** said that the intent of the bill is that there had been a period of eligibility and now the person who passed through that period does not have insurance, even though they could have had it. **Vice Chairman Martin** asked who would pay for the event if the individual chose not to become insured during the event. **Senator Schmidt** responded that those costs would not be paid for by the county or the State. The person incurring the costs would be responsible for payment. **Vice Chairman Martin** asked who would end up paying if the responsible person did not. **Senator Schmidt** responded there would be a cost shift. This bill may marginally affect that situation.

Senator Lee said that the county commissioners in her district do not believe that they are the ones determining indigency, and appeals are filed to fight the original determination, causing more time, money and effort to be spent on this process. **Senator Schmidt** said that the county commissioners are required to make the call and there is inconsistency on how those determinations are made.

Senator Hagedorn asked how much CAT Fund costs had declined in the previous year and what that was attributed to. **Senator Schmidt** said they are seeing less claims but more expensive claims. **Senator Hagedorn** asked about the income levels of those filing claims. **Senator Schmidt** stated that about 2/3 were below 100 percent and about 1/3 above the 100 percent level. This legislation won't solve the whole problem, but it is a start.

Chairman Heider asked who determines who will pay for ER visits if it is an emergency situation. **Senator Schmidt** said care is never withheld based on ability to pay. The ability to pay is usually decided by the hospital based on when they are admitted. Hospitals are working with patients to get them to enroll in health care plans, and they prefer working with insured patients.

Chairman Heider asked for testimonies.

TESTIMONY:

Toni Lawson, testified on behalf of community hospitals, and voiced opposition to this legislation. She is concerned that it would negatively impact low income Idahoans who don't have insurance coverage, cause confusion around the indigent program and CAT Fund eligibility process and result in millions of dollars in cost shifts to physicians, hospitals and other health care providers (see attachment 2). **Ms. Lawson** asked that this Legislation be held until some of the issues she sees are resolved.

TESTIMONY:

Jim Baugh, representing Disability Rights Idaho, a private nonprofit which provides legal and advocacy services for people with disabilities, expressed concern about people with mental illnesses and the effect this legislation would have on them. They have a lot of expenses and need for treatment that is not typically covered by an insurance plan on the Exchange, and being included in the Exchange does not disqualify one from the indigent program. **Mr. Baugh** gave several examples of people having large copays, living within strict budget constraints and not being able to survive financially to illustrate that the Indigent Fund isn't always about large hospital bills. This bill would adversely affect these people. He feels that this bill is not going to encourage people to sign up for insurance. He cited many reasons for people not signing up for insurance; much of it is irrational reasoning, but education is going to be the only answer and that will not happen overnight. This law will only benefit them after they have had a catastrophic event while they were uninsured. He stated that he feels this legislation will only increase confusion in eligibility and result in more litigation.

Chairman Heider thanked Mr. Baugh for his testimony and asked for questions.

TESTIMONY:

Tony Poinelli, with the Association of Counties, began his presentation by stating on page 3, lines 10-19, the qualifying life events are spelled out. The intent of these lines was to indicate that for those individuals in the 100-138 percent level, there were particular circumstances when they were in need. The insurance market does open up for those individuals at varying times during the year. In most cases, the time between when they lose coverage and when the market closes is 60 days. They should have the ability to qualify for CAT and the indigent program during that time. He also stated that the current indigent program can't look at the households rather than the individual. The income level is the income of the person receiving the emergency medical care and possibly the spouse. If medical bills are far more than income level, the individual will likely be deemed indigent regardless of assets. Currently, the hospitals are doing a good job of educating people on this issue.

Chairman Heider asked for questions.

Senator Lee asked what percentage of repayment would be coming back to the counties as individuals repay their obligations. **Mr. Poinelli** said statewide, it is approximately \$2.5-3 million per year coming back into the CAT program. **Senator Lee** questioned who would pay for those people who don't have the money to repay their bills. **Mr. Poinelli** stated that there would be a shift in funds for those individuals who don't have insurance to the providers. Much of the money coming in currently is from people who are paying back their obligations from several years ago. **Senator Tippetts** asked who was going to decide if a person was unable to purchase insurance during the eligibility period. **Mr. Poinelli** indicated that if an application was filed, it would go to Health and Welfare and then to the county. The counties would make the decisions after an investigation.

Senator Schmidt asked the Committee to support this Legislation and recommend it to the floor.

MOTION:

Senator Lacey moved to send **S 1101** to the floor with a **do pass** recommendation. **Vice Chairman Martin** seconded the motion.

Senator Hagedorn stated that he had concerns about the language in this Legislation. He indicated that there were issues with whether to shift costs to the private sector or to have the State pay for them. Decisions also have to be made on who is eligible for state and county support based on their level of income. Because of these concerns, he couldn't support this bill.

Senator Tippetts stated that he was concerned that this bill would not encourage people to buy insurance and take responsibility for their own care and sees it as just another way to shift who pays for the care. He also sees issues with how to determine whether people are eligible to purchase insurance.

**ROLL CALL
VOTE:**

Chairman Heider called for a roll call vote. **Vice Chairman Martin, Senators Schmidt and Lacey** voted aye. **Chairman Heider, Senators Lodge, Hagedorn, Tippetts** and **Lee** voted nay. The motion failed.

ADJOURNED:

There being no further business at this time, **Chairman Heider** adjourned the meeting at 4:55 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Assistant Secretary

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, February 25, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
<u>SCR 109</u>	RECOGNIZING MUSIC THERAPY	Chairman Heider
<u>SCR 110</u>	RECOGNIZING NATIONAL DIAPER AWARENESS WEEK	Sen. Janie Ward-Engelking
<u>H33</u>	RELATING TO SUBSTANCE ABUSE	Casey Moyer, LMSW Program Manager, Policy Unit Division of Behavioral Health
Presentation	Community health emergency medical services	Mark Babson Darby Weston Shawn Rayne

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, February 25, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Lacey

ABSENT/ EXCUSED: Senators Lodge and Schmidt

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.

PASSED THE GAVEL: Chairman Heider passed the gavel to Vice Chairman Martin.

SCR 109 **Chairman Heider** presented **SCR 109**, recognizing music therapy. **Chairman Heider** explained the legislation was inspired by an experience with his sister who became unable to speak due to complications from a surgery. Matthew Jordan had been to her home to provide music therapy, and her daughters told Chairman Heider that the music therapy made a big difference in their mother's life. Chairman Heider later watched Mr. Jordan work with a 17-year-old who was in a nearly vegetative state. During music therapy the patient would participate on the keyboard or handle the drum. It was impressive to watch the young man's progress while Mr. Jordan was there. **Chairman Heider** concluded there are not enough music therapists in the State of Idaho to form a board; however, a concurrent resolution stating the benefits of music therapy would be in the best interests of the people of Idaho. He turned the presentation over to Mr. Jordan.

Mr. Jordan said music therapy started in Idaho in 1950. Currently, Idaho has 15 board-certified music therapists; 12 in the Treasure Valley, 1 in Rexburg, 1 in Montpelier and 1 in Coeur d'Alene. They work in hospitals, retirement communities, hospice, and private practice with a huge array of people with developmental disabilities, dementia, stroke, and with the deaf and hard of hearing. Certification requires a bachelors degree in music therapy and completion of a 1,040-hour internship, or a person with a bachelors degree in music may complete two additional years of schooling and the 1,040-hour internship. There is a masters program and there are two masters level music therapists in Idaho.

Mr. Jordan demonstrated music therapy by playing a guitar and singing "Somewhere Over the Rainbow" with a transition into lyrics tailored to the patient's needs. He gave other examples of helping a developmentally disabled man improve his motor movements and helping a stroke victim who couldn't speak write a song to communicate with her loved ones. He said Senator Gabrielle (Gabby) Giffords credited music therapy with helping her learn to speak again after suffering a traumatic brain injury. He said he appreciated the Committee recognizing music therapy as important work.

Chairman Heider thanked Mr. Jordan and invited questions.

Senator Tippetts asked who certifies music therapists. **Mr. Jordan** said the Certification Board for Music Therapists (CBMT) of the American Music Therapy Association (AMTA) certifies applicants after they complete the education and internship requirements. Continuing education is required to keep the certification.

Senator Nuxoll asked what types of music the music therapists use. **Mr. Jordan** said they look for the music that will be motivating for the client they are working with. They use all types of music with the understanding of what some music does to emotions and feelings.

Senator Lee commented her family saw the difference in a family member who was in a medically induced coma. When the hospital brought in music therapy, there was an incredible change in the patient's blood pressure and breathing.

Senator Nuxoll asked if they do music therapy for pregnant women. **Mr. Jordan** said there is a music therapist in Idaho who focuses on pregnant women and music-assisted childbirth. She is a certified doula as well. **Senator Nuxoll** shared that prenatal classical music and preschool violin lessons have helped calm one of her children who is very active.

Vice Chairman Martin asked for discussion and provided his view that listening to 60s music in a '65 Mustang had helped him feel 16 again.

MOTION:

Chairman Heider moved to send **SCR 109** to the floor with a **do pass** recommendation. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**. Chairman Heider will carry the resolution on the floor.

SCR 110

Senator Janie Ward-Engelking presented **SCR 110** recognizing National Diaper Awareness Week. She said the resolution has bipartisan support and several co-sponsors, including some members of the Committee. She said she thinks this concurrent resolution will show the need for a diaper bank in Idaho and how it fills an important void. She turned her time over to Shawna Walz, Executive Director, Idaho Diaper Bank.

Shawna Walz said the Idaho Diaper Bank was incorporated in April 2014 and received 501(c)(3) status in September. They joined forces with an organization in Caldwell and have developed a statewide model. The Diaper Bank Board (Board) has 16 members, diverse in terms of their backgrounds and talents. They have distributed 5,000 to 10,000 diapers per month for a total of approximately 50,000 diapers. An anonymous donor gave them warehouse space in Meridian from which they can distribute one million diapers, which is their goal. They are members in good standing with the National Diaper Bank. There are 48 other diaper banks in the United States. Through their membership with the National Diaper Bank network they get negotiated bulk pricing.

Ms. Walz said the Diaper Bank is seeking people to be involved statewide, and **SCR 110** would help raise awareness. She explained 80 percent of people surveyed understood the concept of food banks for supplemental food, but only 18 percent had heard about diaper banks as a possible resource. She pointed out disposable diapers are expensive and there is no government assistance for purchasing them. Food stamps and the Women, Infants and Children (WIC) Program do not cover them. She observed that once people hear about diaper need and the crisis, they are very eager to help address the problem by learning about the issue, donating diapers, having diaper drives, volunteering and getting involved.

Ms. Walz shared some statistics about diaper needs and the impact a resolution could have on the community. She related one in three moms report struggling to afford diapers for their children. She said 55 percent of Idaho children age 3 and under were living in low income or poverty. Thirty-nine percent of births in Idaho were financed by Medicaid as of 2010, and the number has been growing. There are approximately 35,000 babies in Idaho whose families struggle to provide diapers.

Ms. Walz explained that children cannot go to early childhood education without a day's supply of diapers. Research shows that children who get early childhood education are almost three times likely to go on to higher education. Children cannot attend most day care facilities without a day's supply of diapers, so a parent cannot go to work or school as a consequence. Diapers are a basic necessity, just like food or shelter, and many families have more than one child they are diapering. Mothers are very resourceful. In desperate situations they may try to clean and reuse a disposable diaper or use a diaper that does not fit. Sometimes parents try to potty train children sooner than they may be ready. The American Academy of Pediatrics says more child abuse occurs during toilet training than any other developmental step. The Board is talking with groups like IdahoSTARS to help make sure that parents have the concrete support they need so they are not in a desperate situation to push kids that might not be ready into potty training.

Ms. Walz concluded the Diaper Bank founders and Board hope the Committee will send **SCR 110** to the floor to help raise awareness and to have an Idaho Diaper Bank Awareness Week at the end of September. She also encouraged the Committee to engage about the topic of diaper need when they are talking to constituents to help the Diaper Bank become a statewide resource for families in need.

Chairman Heider thanked Ms. Walz and invited questions.

Senator Nuxoll asked what the State would have to do to get this recognized and what State monies would be used. **Ms. Walz** said the Board will be organizing many different events during Diaper Need Awareness Week that will not require funds from the State. It would all be handled by community partners. Passage of the resolution would raise awareness that they will use as they go out and talk to people in the communities. **Senator Nuxoll** asked if there was another way to get the information out rather than through the State. **Ms. Walz** said there are a plethora of avenues through social media, and they intend to use all of them because people need to hear the message more than once or twice, and people have different forums that they read for information.

Senator Tippetts applauded Ms. Walz's efforts. He asked if part of the reason she started the Diaper Bank was to find a private solution to the problem rather than ask the State to fund the effort. **Ms. Walz** said absolutely. The Board recognizes there is no government assistance for diapers, and they do not plan to try to change the Health and Welfare system. As a matter of fact, the Board has been contacted by the Department of Health and Welfare (DHW) and other groups looking to tap into the resources that are coming into the community through the Diaper Bank.

Senator Lacey said the cost of doing an SCR is minimal and it is a good thing to do for the Diaper Bank. He applauded what they are doing and offered to give them the benefit of his 15 years of Food Bank experience moving things around through the State. He thanked Ms. Walz and wished her great success.

Chairman Heider said he echoed Senator Lacey. He told Ms. Walz that Senator Ward-Engelking is a wonderful spokesman and to remember the rest of the Committee when the Diaper Bank is looking for representatives around the State to push the movement.

Senator Lee said this is the perfect example of what private and charitable organizations are doing in the community. She said she thinks it is the proper role of the Legislature to bring awareness to a statewide need that does not have implications but provides the opportunity to bring awareness. She said she was proud to be able to support the Diaper Bank.

Senator Ward-Engelking said she was excited to take this on the floor as it was important to have 105 people from throughout the State understand the need. She urged passage of **SCR 110**.

MOTION:

Senator Martin moved to send **SCR 110** to the floor with a **do pass** recommendation. **Senator Lacey** seconded the motion. The motion carried by **voice vote**. **Senator Nuxoll** asked to be recorded as voting nay.

H 33

Casey Moyer, Program Manager, Division of Behavioral Health (Division), Department of Health and Welfare (DHW), presented **H 33** relating to substance abuse.

Mr. Moyer said the Division is seeking to amend sections of this law now covered under Idaho Code Section 39, Chapter 31 – the Regional Behavioral Health Services Act and federal regulations. He said the Alcoholism and Intoxication Treatment Act (AITA) became part of Idaho law in 1975. Since that time there have been a variety of system and legal changes that have moved the practice toward an integrated behavioral healthcare system. When created, the AITA reinforced the now well-embedded principle that the act of using and abusing alcohol and drugs should be met with a response of treatment, not criminalization.

Mr. Moyer said there are two sections of this law DHW proposes to repeal. Section 39-303A established the Regional Advisory Committees (RACS). The RACS have been combined with mental health boards to form Regional Behavioral Health Boards as afforded in Idaho Code 39-3132.

Section 39-308, addresses the requirements related to records of those in treatment. He said since the law's initial passage, additional federal regulations have established a standard of confidentiality and practice that is far beyond that contained in this section. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and CFR 42, Part 2, established in 1987, each raise the bar higher, and federal laws supersede Section 39-308 of the AITA.

Mr. Moyer reported that in discussions with the Association of Counties and partners in the courts, there were no objections to the proposed repeal of the two sections. Further research by the Deputy Attorney General yielded no concerns or legal conflicts being created by the repeal. He said amendment of this chapter would assist the DHW and the system in continuing their shared change efforts. On behalf of the Division and the individuals that they serve, he asked the Committee to advance **H 33** to the Senate with a do pass recommendation.

Chairman Heider said he was reluctant to vote on **H 33** because he had not read the sections it would repeal.

Senator Hagedorn asked if Section 39-308 was replicated in statute elsewhere. He said he was concerned there would be no instructions to keep patients' records confidential if this portion was repealed. **Mr. Moyer** said CFR 42 establishes confidentiality requirements for patients' records, supercedes state law and would be the standard all substance use providers and medical treatment providers would use. Keeping Section 39-308 intact may confuse or confound individuals reading the statute since it was inserted in the 1970s and has not been updated since the passage of the new federal standard which is much higher and more prescriptive than the text in the bill. **Senator Hagedorn** asked if CFR 42 may have changed in the last few days because of any regulation changes that could have been published on the federal registry to CFR 42. **Mr. Moyer** said he had not checked the Federal Register in the past few days, however they are alerted any time there are proposed language changes. **Senator Hagedorn** said he was concerned about relying on a federal regulation that the Legislature does not review as it changes pertaining to the records of Idaho citizens.

Senator Lacey asked Mr. Moyer if it would be better to reword Sections 39-303(A) and 39-308 to conform with the federal regulations, so the sections would still be in Idaho statute where they could be watched. **Mr. Moyer** replied CFR 42 is fairly lengthy in its requirements. It breaks apart different segments of a client's treatment record, and there are different levels of ability to share parts of the file with certain professionals. The section of the statute proposed for repeal is a blanket statement that is difficult to enforce because they have a much more advanced substance abuse disorder treatment system and many more types of records they work with. Removal of the sections may help clarify and reduce confusion about the requirements for confidentiality by having a single source.

Chairman Heider said he would prefer to delay the vote until the Committee had an opportunity to look at both of the statutes.

MOTION:

Vice Chairman Martin moved to hold **H 33** in committee at the Chairman's discretion. **Senator Lee** seconded the motion. The motion carried by **voice vote**. **Senator Tippets** asked to be recorded as voting nay.

PRESENTATION:

Darby Weston, Director, Ada County Paramedics (Agency), presented the Community Health and Emergency Medical Services (CHEMS) Program. He said Mark Babson would give a first-hand view of what they do in the field, and Shawn Rayne would follow up with an overview of how they are structured as an agency.

Director Weston said the Agency has been working for the last five years on what they could do to adapt to change, provide the best level of care, and address the gaps that exist in access to health care for the population they serve. He said Emergency Medical Services (EMS) throughout the State serve as a safety net for all the people. Dialing 911 in a time of crisis gets an immediate response and treatment for illness or injury. There is also a population that calls 911 any time they have a health issue because they have no other access to medical care that they are aware of. For this population, paramedics are the primary care providers, and the paramedics take them to the most appropriate resources. In the current structure of the system, the most appropriate resource is identified as the emergency room. It is also the most expensive resource. He advised that there may be much more cost-effective solutions.

Director Weston said the Agency did not want to recreate a service that was already available in the State or encroach on someone else's area of practice that was already being effectively managed. The Agency gathered all the stakeholders they had access to including the Department of Health, the hospitals, mental health, home health and nursing homes for a long conversation about what the gaps are in health care. The gaps they have identified in Ada County are the people who are discharged from the hospital without the resources they need to learn how to manage the new condition and people who do not have access to health care in the first place. They are people that use 911 as the answer to any medical concern. By design this program would allow the Agency to proactively reach out to them. Now the medical responders only see them briefly, get them to the hospital, then move away from them. If paramedics were able to address them and understand exactly what their needs were and get them pointed in a more productive direction so they could manage their own health far more effectively, that would be a benefit to them and to the Agency. As they were developing it, there was not a model in the United States. They partnered with a university in Colorado and one in Michigan to develop a pilot project to help determine if this was a concept that had value for Ada County.

Director Weston said after stakeholder engagement the next step was to figure out what additional education paramedics would need to provide this service to the community. He explained that EMS professionals are educated at many different levels. The basic entry-level position is the emergency medical technician which takes 120 hours of classroom time to achieve. The advanced emergency medical technician adds an additional 100+ hours and another set of skills. The paramedic starts out at about 650 hours, but most programs are running between 1,000 and 2,000 hours between clinical, didactic and the internship.

They are overseen by the State Bureau of EMS and also by the EMS Physician Commission that sets the scope of practice across the State. The medical scope of practice they deliver to the scene of the emergency is on par with the emergency room of the hospital with critical interventions in the first 30 minutes. They have 12V EKG, defibrillation, cardiac pacing, invasive procedures, and a list of medications to be able to stabilize the emergent condition in the field.

Every EMS agency is overseen by a physician medical director. Ada County has two medical directors to provide the level of support they require and provide a direct tie into both of the primary health care systems in the area. Quality improvement and quality assurance are monitored internally on a regular basis to make sure the professionals are performing at a level of quality that meets the standards of the Agency.

Last year the Agency responded to just under 24,000 calls for service within Ada County. Of that, 5 percent were true emergencies transported to the hospital with lights and siren, 61 percent were transported without lights and siren as the level of call did not necessitate the risk of emergency transportation, and 34 percent were not transported at all because it was determined there was nothing that required intervention by the emergency department. **Director Weston** said the CHEMS program is geared to the lower acuity patients and helping them find better solutions for their health care and giving them better access to receive health care. He turned the presentation over to Mark Babson.

Mark Babson, Paramedic, Ada County Paramedics, highlighted the unique characteristics that will allow CHEMS or paramedics to be integrated into more of a primary care setting. He said:

1. By design, EMS systems deliver care at the point of need which is typically the patient's environment. EMS professionals are very comfortable working in a non-clinical setting. They carry the same equipment and medications you would see in an emergency room or in a clinic. They have honed their skills to communicate with every type of patient whether there is a difference in age, socioeconomic background or language. They have honed the ability to look at the entire situation, not just the patient. They have the ability to assess their environment which is crucial when they are trying to make sure that a care plan is being implemented.
2. EMS has an established communication system. If anything happens, they will be able to get help there right away. Paramedics also have the ability to get online medical direction at any point. EMS professionals are very used to gathering all the information they find on a patient and relaying it back to a medical professional.
3. EMS systems are integrated with all 911 resources such as dispatch, law enforcement, fire department, the hospital and emergency department.
4. EMS professionals are very keenly aware of the community resources that are in their system and why or why not people access them. The most complex and oftentimes most expensive patient will typically initially access the health care system via EMS, so EMS is in a unique position to make a big impact on both cost and positive patient outcomes.
5. EMS professionals are already an extension of the emergency room provider, so to be an extension of a primary care provider or a primary care team would be very easy for them.
6. When a patient's clinical plan that was designed in a clinical setting fails, EMS are the first providers who see that. It gives the paramedic a unique ability to get all the information and relay it back to a patient's medical team.

Mr. Babson said health care is moving into ambulatory care or outpatient services, and that is exactly where EMS professionals are used to working. When you think about a health care delivery system through a patient-centered medical home (PCH) or an Accountable Care Organization (ACO) model, paramedics fit very nicely into that concept. EMS professionals can be the eyes and ears of the patient's medical team. They can help coordinate all the resources that would be involved in that patient medical neighborhood. Here in Ada County, the patients are liking it. They like the relationship that EMS professionals build, they like the information they give back to their team, and they like the overall situation. It can be very locally tailored, so the programs you use depend on the area and where the needs are. Some programs are focusing on transitional care post-discharge. Others are focusing on health and wellness, prevention, or care coordination depending on the need and where the gaps are. **Mr. Babson** thanked the Committee and turned the presentation over to his boss, Shawn Rayne.

Shawn Rayne, Deputy Director of Operations, Ada County Paramedics, said part of his job is overseeing the CHEMS for Ada County.

Mr. Rayne described the Ada County Paramedics' approach to the CHEMS program. They started with 2 full-time equivalents (FTE), giving 4 paramedics three 8-hour shifts as a community paramedic and one 24-hour shift as a regular paramedic in the field. They developed a three-year plan. The first year was engaging stakeholders to determine where the gaps were and where CHEMS services were needed without stepping into other providers' areas of expertise. One of the first gaps that came to the surface was home health because they found EMS was seeing patients who did not qualify for home health. In the CHEMS Program they have been getting patients referred to home health, so they have a great working relationship with the home health agencies in Ada County.

Mr. Rayne next addressed transitions programs with hospital systems. CHEMS approached St. Lukes and got involved in their care transitions program. One goal was to reduce the readmission rate on congestive heart failure patients at 30 days by 3 percent. A study was done and they have been able to reduce the readmission rate by 5 percent. Now they are working with St. Alphonsus as well.

Today when a patient is discharged they get a lot of information in a really short period of time, and they don't know what to do with it. Having a paramedic available to sit down with them and make sure they understand the recovery plan and the medications they are on, look at all the other medications they have at home to be sure they don't double up on medication, and make sure their primary care physician is up to date puts patients on a good footing to be able to manage their health and proceed out of the system without having to go back to the hospital.

Mr. Rayne described how CHEMS has assisted the county with their flu vaccine and wellness programs by taking vaccines and biometric screenings out to the workplace. This increased the percentage of employees getting flu shots to 68 percent.

Mr. Rayne next spoke about at-risk field referrals. When a firefighter, police officer or paramedic in Ada County responds to a 911 call from a frequent caller, they can fill out a referral form, and a community paramedic will respond to see what resources the patient really needs instead of taking them to the emergency room in an ambulance. They have some really good success stories.

Mr. Rayne said the biggest program they are running is an Emergency Department Diversion Program for mental health crises. Prior to this program, when someone called 911 with a mental health crisis, a police officer would go out and put them on a 24-hour mental hold. The officer or an ambulance would take the caller to a hospital emergency room which generated a \$2,500 hospital bill. The emergency department would send the patient to a psych facility where they would generate another \$2,500 to \$5,000 bill for the patient. Community EMS has formed a team with a law enforcement officer, a social worker from the Mobile Crisis Unit, and a community paramedic. The community paramedic goes out and does a medical screening to see if the patient can avoid the emergency room and just go to the psych facility. Seven months into their beta test they found they were able to divert more patients all the way out of the system. A vast majority of these patients' primary payer is no payer, and indigent services ends up picking up the bill. It has been a very successful program and has kept CHEMS really busy.

Mr. Rayne said the final thing they do is the Tuberculosis (TB) Direct Observation Therapy Program where they go out to watch TB patients take their medications. They are tough medications. The paramedic makes sure the patient takes the pill and watches for a few minutes to make sure the patient is OK. DHW has contracted with EMS to go out and do that if Central District Health doesn't have someone available on a weekend or if the patient is homeless or hard to find. **Mr. Rayne** turned the presentation over to Director Weston for a wrap-up.

Director Weston said since they started this, CHEMS has gained traction across the country. **H 33** is going to the House Health and Welfare Committee to define community medicine, community paramedic, and to authorize the ambulance taxing districts to provide this service to the community. Every community has different needs, density, demographics, and funding sources or mechanisms so the system evolves around what the need truly is as opposed to a cookie cutter approach. What they've seen so far is that there is a good value created, and it is something they would like to continue to develop and expand, creating a model that can be adjusted by many different communities across the State. **Director Weston** thanked the Committee and stood for questions.

Chairman Heider said obviously the system is working in Ada County, and it is a wonderful model. He asked Director Weston how it could be spread throughout the State and at what cost. **Director Weston** said defining it in the Idaho Code would allow the EMS Bureau and the Physician Commission to draw the model beyond what Ada County has experimented with, and then it could be adapted to other communities. In Ada County they look at it as a model that will have to fund itself. Some aspects of funding will be current tax revenues they generate, future downstream savings, and reimbursement from the indigent fund later down the road. If they can intervene up front with a much lower cost resource and get frequent users to the point where they can manage their own health effectively, then the downstream savings will fund what they need. In the past, if a patient was readmitted to the hospital within 30 days of being discharged for a particular procedure, the hospital got paid. But with the changes in health care, that's not a true statement any more.

Senator Hagedorn asked if there were any other funding mechanisms like Medicaid. He also asked if there was a mechanism to recognize the amount of savings due to this program. **Director Weston** replied Ada County Paramedics is an enterprise fund. They operate an ambulance taxing district and about 35-40 percent of their total operating budget comes from their tax bases. The other 60-65 percent comes from the fees they charge for their service. The pilot CHEMS project was 100 percent funded out of those funds. The reason they are doing pilot projects now is to be able to drill down and figure out the savings. With the results they have seen from the Mental Health Crisis Diversion project, he thinks the savings to the CAB Fund will be quite substantial because a lot of those payments come out of the CAB Fund for the reimbursement. As they work with the hospitals, they are looking very carefully at exactly what it costs to bring a patient back in and figuring out the value of that service to the hospital. St. Alphonsus is funding an MBA intern to study that piece for the hospital.

He said going forward there will be a broad spectrum of payers. Some work will be done on contract with the medical facilities themselves. Sometimes Medicaid and Medicare will pay because they have a large set in the population CHEMS is serving. Others will be private payers. **Director Weston** said CHEMS is trying to figure out how to develop the model so they get funding from each of those sources for long-term sustainability. He suspects the biggest challenge will truly be the CAB Fund because the structure of that fund is completely reactionary.

Vice Chairman Martin asked if approximately 40 percent from taxes and 60 percent from fees was the correct ratio of funding. **Director Weston** said yes. **Vice Chairman Martin** asked if the 40 percent taxes were solely Ada County taxes or if there were other tax sources. **Director Weston** said the 40 percent is an \$85,000 a year tax they receive from the license plate fees for EMS. They utilize that percentage for the operation of the joint powers authority they have entered into with all the fire districts that provide EMS within the boundaries of Ada County. He is not aware of any funds other than the taxation of the ambulance taxing district. **Vice Chairman Martin** said this has been very educational. He asked what they want from the Legislature, legislation, money, or something else? **Director Weston** said they are not asking for money. He believes if they cannot develop CHEMS as a self-sustaining program, then they do not have a model that is worth continuing forward with. He asked that if **H 33** is successful in the House and reaches this Committee, that the Committee would consider it in a favorable light.

Senator Nuxoll asked if CHEMS was coordinating with home health or replacing them. **Director Weston** said the CHEMS function is simply to refer to the appropriate health care provider. He said home health and hospice provide a range of services far beyond CHEMS capabilities or interest.

Chairman Heider asked Director Weston if CHEMS is tied in with the Statewide Healthcare Innovation Plan (SHIP) Program and SHIP grant. He said it deals with total wellness, follow-up care and post-surgical care to develop a model very similar to what he described today. **Director Weston** said Mr. Babson has a very good relationship with the folks in the SHIP Program. Part of that, to his understanding, is grant funding to develop education around this kind of a delivery model. CHEMS also provides the personnel who deliver the education in the Paramedic Sciences Program at Idaho State University. A Paramedic Sciences Program and community paramedic training are some of the concepts that they are looking to fund with the SHIP grant as this process moves forward.

Chairman Heider said it is wonderful they are collaborating with all the parties including Idaho State University. He emphasized it will be nice to have the answers bundled together so that everyone gets the benefit that Ada County is getting now through their services. He said the presentation was informative and enjoyable, and the Committee appreciated the time they spent to share it.

ADJOURNED : There being no further business, **Chairman Heider** adjourned the meeting at 4:35 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Paula Tonkin
Assistant Secretary

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, February 26, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
<u>RS23655</u>	REQUEST FOR UNANIMOUS CONSENT FOR RS23655 - Reviewed on 2/19, placed on Agenda in accordance with procedure.	Chairman Heider
<u>RS23704</u>	REQUEST FOR UNANIMOUS CONSENT FOR RS23704 to be heard in Privileged Committee - Relating to CAT Fund Cleanup	Senator Schmidt
<u>H 33</u>	RELATING TO SUBSTANCE ABUSE - Title 39, Chapter 3, Sections 39-303A and 39-308 included.	Casey Moyer, LMSW Program Manager, Policy Unit Division of Behavioral Health
<u>HCR 5</u>	RELATING TO AMERICAN DIABETES MONTH Recognizing American Diabetes Month in November and Supporting Goals and Ideals of American Diabetes Month	Rep. Janet Trujillo

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, February 26, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Lacey

**ABSENT/
EXCUSED:** None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** welcomed everyone in attendance and convened the meeting at 3:00 p.m.

UC REQUEST: **Chairman Heider** asked for Unanimous Consent to print **RS 23655** and to be sent to Judiciary and Rules. There were no objections.

Chairman Heider and **Vice Chairman Martin** explained the purpose of this RS and why it was on the agenda. **Chairman Heider** asked for unanimous consent to send RS 23655 to a privileged committee for a print hearing. There were no objections.

UC REQUEST: **Senator Schmidt** asked for unanimous consent to print **RS 23704** and to be sent to Judiciary and Rules. There were no objections.

This legislation contains two policy changes. As it is now, the CAP Fund can only pay for hospital and provider services. CAP cannot pay for patients in skilled care facilities. This legislation changes the statute to allow patients to be moved to a skilled care facility and have indigent funds applied to their costs. Another change defines the application, to ensure that the indigent fund is used as a last resort.

Chairman Heider asked for unanimous consent to send **RS 23704** to a privileged committee for a print hearing. There were no objections.

H 33 **Relating to Substance Abuse:** **Casey Moyer**, Program Manager with the Division of **Behavior Health**, presented **H 33**. **Mr. Moyer** said there were two major changes. Section 39-303A talks about regional advisory committees. Such committees have been absorbed into regional health boards and are no longer in existence. The second change is the removal of Section 39-308. This is related to the confidentiality of patient records. Since the laws initial passage, additional federal regulations established a standard of confidentiality and practice that is far beyond that contained in this section (see attachment 1).

MOTION: **Senator Lee** moved to send H 33 to the floor with a **do pass** recommendation. **Senator Schmidt** seconded the motion. The motion passed by **voice vote**. Senator Heider will sponsor the bill on the floor.

HCR 5: **Relating to American Diabetes Month: Janet Trujillo**, Representative for District 33 covering Idaho Falls, presented **HCR 5**. She began by stating that this concurrent resolution is meant to bring diabetes awareness to Idaho. There are 100,000 Idaho adults living with diabetes, 84,000 with pre-diabetes and 15,000 mothers with gestational diabetes. It is the seventh leading cause of death in Idaho. Insulin has become one of the most studied molecules in history. Sir Fredrick Grant Vanting is said to be the first person to use insulin on a human. His birthday is in November, and for that reason the American Diabetes Month is in November. Nursing students from Idaho State University will be in Walgreens in the Idaho Falls area during the month of November to present public awareness. She challenged the Committee to get involved in similar awareness programs in Idaho. A letter in support from Walgreens was provided (see attachment 2). **Representative Trujillo** asked to have **HCR 5** sent to the floor with a **do pass** recommendation.

Chairman Heider indicated that two people were going to testify on behalf of **HCR 5**.

TESTIMONY: **Sonja Schrever**, Chief of the Bureau of Environmental Health, Department of Health and Welfare (Department), testified in support of **HCR 5**. She said the Department of Health and Welfare maintains an Idaho Diabetes Prevention and Control Program and this resolution would support many of those programs. The Department plans to support Diabetes Awareness Month. Marketing materials will be distributed during November and that information is connected to evidence-based programs showing the need for diabetes prevention.

TESTIMONY: **Pam Eaton**, President/CEO of Idaho Retailer's Association and independent pharmacists, spoke in support of **HCR 5**. Walgreens has committed to working with any Legislator in any district where a Walgreens exists to promote Diabetes Awareness Month. Other commitments have been made from other pharmacies as well. Many pharmacies are currently involved in diabetes testing and counseling year round. Pharmacies are interested in helping communities control this disease. She encouraged the passage of **HCR 5**.

Chairman Heider asked how Committee members could get involved in Diabetes Awareness Month. **Ms. Eaton** said she would notify the Legislators of the plans the pharmacies have in their areas to promote diabetes awareness in November. They are open to ideas by the Legislators.

Chairman Heider turned the time back to Representative Trujillo.

Representative Trujillo stated that testimony from one of her constituents would be attached to the minutes (see attachment 3). Information regarding driving safely with diabetes was provided (see attachment 4).

MOTION: **Vice Chairman Martin** moved to send **HCR 5** to the floor with a **do pass** recommendation. **Senator Tippetts** seconded the motion. The motion carried by **voice vote**.

ADJOURNED: There being no further business **Chairman Heider** adjourned the meeting at 3:20 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Assistant Secretary

House Bill 33 – Sponsor Talking Points

A Summary & Analysis HB33 Amending I.C. §39-301

Prepared by the Division of Behavioral Health, Policy Unit 2/26/15

History of the Act:

In 1967, three authoritative commissions, the United States Crime Commission, the District of Columbia Crime Commission and the Cooperative Commission on the Study of Alcoholism, concluded that criminal law sanctions were an ineffective, inhumane, and costly method for the prevention and control of alcoholism and public drunkenness. All three commissions recommended that a public health and rehabilitation approach be substituted for the prevailing criminal law sanctions. In response to these recommendations, the American Bar Association, together with the American Medical Association, drew up a model statute called the Uniform Alcoholism and Intoxication Treatment Act, which was subsequently adopted, in whole or in part, by twenty-two states, including Idaho.

The enactment of the AITA by the Idaho Legislature in 1975 reflected an increasing awareness that treatment, rather than criminal penalties, was the appropriate response to alcoholism. Through the AITA, the state sought to eliminate criminal sanctions and provide satisfactory alternatives to the arrest procedure, including making available facilities for treatment as well as procedures for bringing individuals into contact with treatment facilities. The AITA establishes Idaho Department of Health and Welfare (IDHW) as the state Substance Abuse Authority (SSA) and directs the Board of Health and Welfare to; establish a comprehensive and coordinated program for treatment, develop standards for approved treatment facilities, and periodically inspect approved facilities. Under the authority of the AITA, the IDHW has promulgated rules that establish standards to be met for approved treatment facilities and procedures for approval. The infrastructure for meeting the regulatory requirements of the AITA has been established and a system for management and oversight is in place.

As the Behavioral Health system continues its journey towards integration, changes in other sections of law have necessitated amendment to several subsections.

Proposed Repeal Sections:

Section	Description and Analysis
39-303A	Purpose: Establishes to Regional Advisory Committees (RACS) Repeal Rationale: Regional Behavioral Health Boards are afforded in Idaho Code 39-3132 passed last legislative session. Repeal of this section supports the following: <ul style="list-style-type: none">• Reduces confusion• Eliminates potential conflict between a new and older statute• Ensures clarity for Regional Behavioral Health Board implementation
39-308	Purpose: Ensure confidentiality of client records Repeal Rationale: Newer privacy and confidentiality laws passed after AITA have increased the standards and legal requirements of practice. Specifically: <ul style="list-style-type: none">• Health Insurance Portability and Accountability Act (HIPAA)

(<http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/html/PLAW-104publ191.htm>) established privacy standards for protected health information in the arenas of electronic transactions, provider identifiers, health insurance plans and employers – Enacted in 1996

- Central Federal Registry (CFR) Title 42, Public Health, Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records (<http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2#sp42.1.2.b>) outline strictest requirements for client records – Enacted in 1987
- IDAPA 16.05.01.250 (Disclosure of Department Records) addresses the Departments responsibility to protect substance use disorder records.
- Idaho Code 37-3102 also affirms confidentiality of substance use treatment records.
- Removal of the subsection will reduce confusion and potential conflict with existing confidentiality and privacy laws

Additional Information:

- The Association of Counties and Supreme Court were consulted; repeal of these sections yielded no objections.
- There is no fiscal impact anticipated with passage of this bill
- There is no operational impact of change
- Passage of this bill ensures efficient government and furthers the legislators' commitment to policy reform



Representative Trujillo

Walgreen Co.
Government Relations
104 Wilmot Rd. MS 1459
Deerfield, IL 60015
P 847-315-4653 F 847-315-4417
walgreens.com

Walgreens is happy to support the resolution "Recognizing American Diabetes Month in November and Supporting the Goals and Ideals of American Diabetes Month."

Walgreen Co. (Walgreens) operates over 8,200 drugstores in 50 states, the District of Columbia and Puerto Rico. In the state of Idaho, Walgreens operates 41 pharmacies to serve all this state's healthcare needs.

Walgreens is committed to promoting public health by improving the health of all Americans. To help the approximately 80 million American adults and children living with diabetes or pre-diabetes, Walgreens offers health testing for Hemoglobin A1C and blood glucose at more than 4,000 U.S. locations. Walgreens pharmacists conduct A1C and blood glucose tests with a quick finger stick. Tests are available to people 18 and older at 39 testing locations in Idaho during pharmacy hours daily with no appointment necessary. All customers getting a health test will receive a consultation to help them understand results and next steps.

Further, Walgreens pharmacists, across this state and the nation, have been central to the ongoing advancement of community pharmacy, providing a wider range of health care services and working more closely than ever before with other providers to ensure continuity of patient care. With a greater need for access to health care services, the company has pharmacists with specialized training to help manage a growing number of chronic conditions such as diabetes. Diabetes management is critical for patients to live happy and healthy.

Attachment 3
HCR 5

From: Pat Tucker [ccrtucker@gmail.com]
Sent: Thursday, February 26, 2015 5:08 AM
To: Representative Janet Trujillo
Subject: Statement

Rep. Trujillo:

My quick statement:

Car crashes are the number 1 cause of death of our country's youth of all ages from 2 to 36. I know this only too well because my dear, beautiful, talented only child, Cathryn Claire Rose Tucker, was robbed of her life at age 11 when an insulin-dependent diabetic driver with uncontrolled blood sugar had a diabetic episode just ONE-HALF HOUR after taking over the wheel. Cady would be 24 today. I cry for Cady nearly every day and still cannot process the magnitude of the loss. I IMPLORE insulin-dependent drivers and ALL drivers to stop driving when alertness is threatened by low or high blood sugar, hypoglycemic unawareness, drowsiness, anxiousness, anger, you name it. STOP--take 15 minutes. If you're a diabetic, eat a snack, check your blood sugar, and when it's okay, get back behind the wheel. This break is a matter of life and death. Please DRIVE SAFELY. Death cannot be undone.

American Diabetes Association Website

(<http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/hypoglycemia-low-blood.html>)

Driving Safely with Diabetes (<http://www.diabetes.org/living-with-diabetes/parents-and-kids/everyday-life/driving.html>)

Here are some rules of the road:

- **Pass the test.** Check your blood glucose (blood sugar) level before getting into the car. Every time. No exceptions.
- **Stop for a diabetes red light.** Treat low blood glucose and then recheck in 15 minutes. Do not get behind the wheel until blood glucose is in the target range.
- **Slow down.** Treat your blood glucose even if it means being late. It's never okay to drive with a low blood glucose level. Call whoever is waiting for you and explain why you'll be a little late. They'll understand.
- **Always have enough fuel.** Stock the car with healthy, non-perishable snacks and fast-acting sugars. And keep your diabetes supplies within easy reach.
- **Pull over.** Pull over immediately if you are feeling sick or low while driving. Check your blood glucose, treat yourself, wait 15 minutes and then recheck.
- **ID, please.** Don't leave home without a driver's license and medical ID bracelet or necklace. Always wear a medical ID.

Check Before You GO

Get into the routine to check your blood glucose level **before** going places.

Riding in a car with a low blood glucose level is dangerous – and driving is even worse, it's similar to driving drunk. So be sure your teen always checks his blood glucose level before getting in the car.

There are precautions that people with diabetes should take to ensure they are safe behind the wheel.

- Always check your blood glucose before you get behind the wheel and at regular intervals during long drives.
- Always carry your blood glucose meter and plenty of snacks — including a quick-acting source of sugar — with you when you drive.
- Pull over as soon as you feel any of the signs of low blood glucose (hypoglycemia), and check your blood glucose level.
- If your blood glucose is low, eat a snack that contains a fast-acting sugar source such as juice, non-diet soda, hard candy, or glucose tablets. Wait 15 minutes and check your blood glucose again to make sure it's at your target range before you resume driving.
- Examples of Snacks with 15 grams of glucose: glucose tablets, gel tube, 2 tablespoons of raisins, 4 ounces (1/2 cup) of juice or regular soda (not diet), 1 tablespoon sugar, honey, or corn syrup, 8 ounces of nonfat or 1% milk, hard candies, jellybeans, or gumdrops (see package to determine how many to consume)
- If you experience hypoglycemic unawareness, stop driving and consult your health care provider. Do not resume driving until awareness has been reestablished.
- Get regular eye exams for early detection of diabetes-related vision problems that can affect your driving ability

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, March 02, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for February 3, 2015	Senator Hagedorn
	Approval of the Minutes for February 11, 2015	Senator Tippetts
<u>RS23704C1</u>	REQUEST FOR UNANIMOUS CONSENT FOR RS 23704C1 to be heard in Privileged Committee - Relating to CAT Fund Cleanup	Senator Schmidt
Gubernatorial Appointment Hearing	James V. Giuffre for reappointment to the State Board of Department of Health and Welfare.	James V. Giuffre

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, March 02, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee and Jordan

ABSENT/ EXCUSED: Senator Schmidt

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:04 p.m.

MINUTES APPROVAL: **Senator Hagedorn** moved to approve the Minutes of February 3, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.
Senator Tippetts moved to approve the Minutes of February 11, 2015. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**.

UC REQUEST: **Chairman Heider** asked for unanimous consent to send **RS 23704C1** to a privileged committee for a print hearing. There were no objections.

GUB APPT: **Senator Heider** introduced **James V. Giuffre** as the candidate for reappointment to the State Board of Health and Welfare (Board).

James Vincent (Jim) Giuffre stated he has lived in the State of Idaho for almost 40 years. He has served one term on the Board and would like to continue to serve. He was formerly Director of the North Central Idaho District Health Department and Health Director of the Central District Health Department in the Treasure Valley. He said he has stayed close to the Legislature in its dealings with the Department of Health and Welfare (DHW). Today he serves as Chief Operating Officer of Healthwise, a nationally known consumer health information company. They produce health information in print and electronic formats used by almost every health plan in the country including Cigna, Aetna, and Kaiser Permanente and many of the major Idaho health systems including St. Luke's, St. Alphonsus and others.

Mr. Giuffre said he obtained an undergraduate degree in biology from the University of California, Santa Cruz, and a masters degree in public health from the University of California, Berkeley. His experience on the Board has primarily focused on rules and regulations, but he is very passionate about improving access to care for all Idahoans. He said he will stay very close to the development of the patient-centered medical home (PCH) initiative now funded by the federal government Center for Medicaid Services. **Mr. Giuffre** emphasized that he advocates helping people make better health decisions and has focused his lifestyle on that. He said he would appreciate the opportunity to serve again, and he would be happy to answer any questions.

Senator Heider said as a Board member himself, he appreciates Jim and the other members of the Board because they are very in-depth in their questioning, they have a great deal of background and it is a pleasure to watch them work.

Senator Nuxoll asked Mr. Giuffre what he considered to be the best thing and the worst thing that have happened in health care in the last five years. **Mr. Giuffre** said the best thing has been electronic health records because they give the care team access to everything about the patient, thus helping the patient and care team make much better health decisions. **Mr. Giuffre** said the challenge he sees is how to get everyone under the umbrella of the lowest cost health care service that is most appropriate for them. Too many people are using emergency rooms at the highest cost for entrance into the hospital systems. He said the opportunity exists to get people under the health care umbrella through the Idaho Exchange, the expansion of Medicaid and the PCH initiatives. He feels those opportunities will encourage more individual responsibility for health and systems to support their decisions.

Vice Chairman Martin asked Mr. Giuffre's perspective on the fee-for-service system versus the care management system. **Mr. Giuffre** said the fee-for-service system has been good, but it primarily rewards performance of more services. It is structured so the more the system does for an individual the higher the payment mechanism in place for it today. He said care management really allows the most appropriate care at just the right moment in time and rewards outcomes and value. He believes there is a ground swell movement where health systems and clinicians will take more risk, therefore they should be paid for taking on that risk and performing only those services that really assist individuals in their personal health care decisions.

Senator Nuxoll mentioned she saw that Mr. Giuffre holds a first degree black belt in karate. She asked why he got it. **Mr. Giuffre** said he received it more than 30 years ago primarily for personal development in mental and physical discipline. The greatest reward he had was in teaching young children to develop self-confidence and skills. He does not practice karate as much today, but it's still an important part of his life.

Senator Hagedorn said Idaho Code § 56-1005 requires that not more than four members of the Board appointed by the Governor shall be from any one political party. He noted on the application that Mr. Giuffre did not say one way or another. He asked Mr. Giuffre what political party he is registered with, if he is registered. **Mr. Giuffre** said he is registered as a Democrat, however as an independent Idahoan he votes for the best qualified person.

MOTION:

Vice Chairman Martin moved to send the gubernatorial appointment of James Giuffre to the State Board of Health and Welfare to the floor with recommendation that he be confirmed by the Senate. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

ADJOURNED:

There being no further business, **Chairman Heider** adjourned the meeting at 3:18 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Paula Tonkin
Assistant Secretary

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, March 03, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
<u>SCR 111</u>	RELATING TO FAMILY CAREGIVERS - Findings and creating a task force to study issues related to Family Caregivers	Dr. Sarah Toevs , Director Boise State University Idaho Caregiver Alliance, Center for the Study of Aging

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, March 03, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Lacey

**ABSENT/
EXCUSED:** None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Health and Welfare Committee (Committee) to order at 3:05 p.m. and welcomed Dr. Sarah Toevs to the podium to introduce **SCR 111**.

SCR 111 **Dr. Sara Toevs**, Director, Boise State University Idaho Caregiver Alliance, Center for the Study of Aging, presented **SCR 111** relating to family caregivers. The concurrent resolution calls for the Idaho Caregiver Alliance, a statewide consortium led by the Idaho Commission on Aging and the Boise State University Center for the Study of Aging, to convene a broad group of stakeholders to identify policies, resources and programs available for family caregivers and encourage additional innovative means of support.

Dr. Toevs said caregiving has become an increasingly complex lifespan challenge and an immeasurably important part of the State's and the nation's, healthcare delivery system.

Dr. Toevs said the value of the support provided by unpaid caregivers is estimated at \$2 billion annually, and every month's delay in the need to send an individual to an assisted living facility supported by Idaho dollars saves state resources. She said the average cost of an assisted living facility in Idaho is about \$3,200 per month, and that cost doubles in a skilled nursing facility.

Dr. Toevs said the concurrent resolution will bring together diverse agencies and organizations, public and private, to discuss methods of working together to support caregivers. She said the resolution also connects legislative policymakers as an important component of the overall program.

In summary, **Dr. Toevs** said the task force will explore and develop cost-effective ways of helping individuals of all ages continue in their role as unpaid caregivers. She asked for the Committee's support of **SCR 111** and stood for questions.

Senator Nuxoll asked why there was not a monetary value placed on the fiscal note. **Chairman Heider** explained the situation and said a specific monetary value, if any, has yet to be determined.

Committee members asked questions about education, resources and reimbursement to legislative participants. **Dr. Toevs** addressed those questions and explained that individuals testifying would also clarify any concerns. **Senator Lee** commented that the new language in the resolution is consistent with what the Committee had requested.

TESTIMONY: **Alyssa Aldrich**, Eagle, Idaho, testified in support of **SCR 111**. She represented herself as the mother of a disabled child. **Ms. Aldrich** described the difficulties imposed on families who provide round-the-clock care and said she is on a mission to help fill the gap for caregiver respite needs. She is cofounder of a nonprofit organization toward that end.

Tracy Warren, Program Specialist, Idaho Council on Development Disabilities testified in support of **SCR 111**. She described the 23-member volunteer council appointed by the Governor to promote access to quality supports for people with developmental disabilities and their families. She said the need most often identified by caregivers is access to information on resources and programs to enhance the quality of life for loved ones and provide respite to caregivers. **Ms. Warren** said this concurrent resolution will provide an entity that focuses specifically on these needs.

Jill Harriss testified in support of **SCR 111**. She is the caregiver for her husband who was diagnosed in 1999 at age 29 with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease, and has required round-the-clock care for the past 11 years. **Ms. Harriss** described the difficulties attendant with round-the-clock care and said the family has paid \$85,000 out of pocket to private caregivers. She said burnout, financial strain and government assistance may have been avoided or diminished if information on resources and support had been available.

Joe Loiacono, Executive Director, Inland NW Chapter, Alzheimer's Association serving north Idaho, testified in support of **SCR 111** as a veteran and as someone whose mother has Alzheimer's disease. He asked the Committee to consider veterans who are dealing with this issue, either as a caregiver or as a disabled individual. He said Idaho needs to prepare for the growing numbers of veterans who have returned home from recent wars with traumatic brain injuries and stressed that this task force will be part of that preparation.

Peggy Munson, a volunteer with the American Association of Retired Persons Idaho (AARP) and former geriatric nurse and caregiver, testified in support of **SCR 111** and answered earlier questions concerning available educational material and other resources. She said AARP regularly publishes information on many of these resources which is available to the public. She stressed the importance of preparation and said an entity that will bring together these needed resources will be of immense value.

Dr. Toevs summarized her presentation and asked the Committee to support **SCR 111**.

MOTION: **Vice Chairman Martin** moved to send **SCR 111** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion. The motion passed by **voice vote**. Vice Chairman Martin will carry the resolution on the floor.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:09 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne Clayton
Assistant Secretary

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, March 04, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
<u>S 1121</u>	RELATING TO THE IMMUNIZATION REGISTRY	Vice Chairman Martin
<u>H 108</u>	RELATING TO PHARMACY - Amending to revise language relating to the practice of Pharmacy	Rep. Christy Perry

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, March 04, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:10 p.m.

S 1121 **Vice Chairman Fred Martin** presented **S 1121**, relating to the immunization registry. He said **S 1121** amends Idaho Code § 39-4803 to allow the Idaho Immunization Registry to share data with the Idaho Health Data Exchange (IHDE). The Idaho Immunization Registry was created by statute in 1999. It is a confidential computer system that provides health care providers access to immunization records. The IHDE was created in 2008 to compile data from various sources into a single electronic media medical record to give health care providers a more complete picture of the care their patients are receiving. The IHDE is completely unrelated to the Idaho Health Insurance Exchange or Your Health Idaho. In their 2014 annual report to the Committee, the Idaho Health Quality Planning Commission identified creating a gateway between the Immunization Registry and the IHDE as one of the most important requirements that they were working on. These changes are supported by the Idaho Department of Health and Welfare (DHW), the IHDE, the Idaho Medical Association, and the Idaho Association of Health Plans. **Vice Chairman Martin** stood for questions and said there were people in the audience ready to answer questions related to this proposal.

Senator Nuxoll asked Vice Chairman Martin if he had checked with any of the people from the previous hearing who were against the sharing of immunization information. **Vice Chairman Martin** said he had not. He had made sure there was an opt-out provision so those who might have concerns would have the opportunity not to participate. **Senator Nuxoll** asked how people were notified that they could opt-out. **Vice Chairman Martin** referred the question to Scott Carrell.

Scott Carrell, Executive Director, IHDE, responded that the opt-out process is voluntary. He said IHDE provides the forms to all of their data sources to make publicly available. Any Idaho resident who chooses to opt-out can submit the forms to IHDE. IHDE takes a second step to confirm with the resident that they know what they are opting out of and that they know the system will allow the resident to rescind that request later if they choose.

Senator Nuxoll asked Director Carrell if people can opt-in if they have not been to a doctor. **Director Carrell** said IHDE has notification processes with their participants who engage with the patients. IHDE has privacy and security regulations and policies that they monitor very carefully because of the sensitivity of the data. Participants are obligated to abide by the regulations and inform the patients of the information contained in the system and the use of it. **Director Carrell** said he can only speak to the provider population who have signed up with the IHDE.

Senator Tippetts asked why the language on page 2, lines 23 and 24, is being stricken. **Director Carrell** deferred to Shad Priest, Director of Government Affairs, Regence Blue Shield of Idaho. **Mr. Priest** said that section, if applied literally, would have required the DHW to go out and erase data stored in third party databases and files. It wasn't practical. Instead, they struck the language and added language in line 30 that all information coming from the Immunization Registry has to be treated as protected health information (PHI). It applies to all health care providers and anyone who handles the PHI of others. The State and federal laws in place protect this information and impose strict requirements on its use. **Senator Tippetts** asked if they notify the controllers of other databases that there is information to be removed from their database. **Mr. Priest** deferred to the DHW to answer the question.

Christine Hahn, M.D., Medical Director, Division of Public Health (Division), DHW, said currently they do not share data with other databases because they have long recognized it was an almost impossible provision. To avoid that, they do not currently share data other than one-on-one with a provider who goes into the registry and looks up a particular chart. **Senator Heider** asked if she would like to offer other testimony. **Dr. Hahn** said she came to testify in support of **S 1121**. The information that will go to health care providers is already available in their registry, but if it is in the IHDE, the providers who are getting x-rays or other medical information through that exchange will have the immunization data in the same place as they evaluate the patient. She said the Division is in support of **S 1121**.

Rebecca Coyle, American Immunization Registry Association, testified on behalf of herself in support of **S 1121**. She supports the bill primarily because of the clause that Senator Tippetts just mentioned that is preventing the real-time exchange of information for parents and providers. This change would update the practice. The risk of not passing **S 1121** is that electronic health record systems will not be updated and people may receive unnecessary vaccinations. She encouraged the Committee to vote in favor of **S 1121**.

Vice Chairman Martin concluded by saying he would appreciate the Committee's support of **S 1121**.

MOTION:

Senator Hagedorn moved to send **S 1121** to the floor with a **do pass** recommendation. **Senator Lodge** seconded the motion. The motion carried by **voice vote**. **Senator Nuxoll** asked to be recorded as voting nay.

H 108

Representative Christy Perry, District 11, Canyon County, presented **H 108**. She said the bill is the culmination of a year's worth of research, engagement of stakeholders, and work of the Prescription Drug Work Group and the Idaho Office of Drug Policy (IODP). She said the Prescription Drug Work Group is a consortium of volunteers from law enforcement, education, psychology, the medical and dental fields, and various members of the public who come together to work on drug issues within the community. Prescription drug use has escalated in Idaho to the extent that more people have died of prescription drug overdoses in the last several years than from car accidents. Many of those are accidental. The increase of usage is a national trend. The Idaho Legislature and the IODP have taken steps in the last several years to combat the issue. Action has been taken to educate the public, changes have been made to the prescription monitoring program, and the public has been informed that pharmacies keep track of their prescriptions. All of this has helped curb prescription drug use. However, it has been reported by law enforcement that these changes also seem to cause an uptick in non-prescription illegal drug use. Opioids are drugs that relieve pain and exist in both legal and illegal forms. Examples of legal prescription opioids are Vicodin, Percocet and morphine. Examples of illegal non-prescription opioids are heroine and methamphetamine (meth).

Representative Perry said the purpose of **H 108** is to allow people who are associated with someone who may be a prescription or non-prescription drug abuser access to an opioid antagonist drug called naloxone. An opioid antagonist is used exclusively in the reversal of opioid overdoses. It is temporary. When naloxone is administered to a person who has overdosed, it will immediately bring them out of that overdose until you can get medical attention to them. A 2014 report by the Network for Public Health Law states that fatal drug overdoses account for the loss of more than 36,000 American lives each year. The epidemic is mostly driven by prescription opioids such as OxyContin and hydrocodone, which now account for more overdose deaths than heroine and cocaine combined. The report goes on to state that opioid overdose is typically reversible through the timely administration of the medication naloxone with subsequent medical care. However, laws dealing with naloxone are antiquated and they predate this drug epidemic. In an attempt to reverse or arrest the uptick, many states are amending those laws and removing legal barriers to increase access to naloxone and medical care based on studies. Today 28 states have an active version of naloxone access laws since 2001, and that's what's being asked of the Committee.

Representative Perry said naloxone is not a controlled substance and it has no abuse potential. It is not harmful to any person who may be accidentally injected or have no use for the medication. According to the Network for Public Health Law report, naloxone can be administered by citizens with little or no formal training. Since overdoses occur primarily when the patient is with family or friends, those family members may be the best situated to act should an overdose occur. In 2012, the American Medical Association (AMA) adopted a new policy at their annual meeting in support of naloxone access laws. Many overdose deaths in Idaho, especially in rural areas, are caused by lack of access to medical services. Overdoses could be prevented through this relatively cheap, safe, and effective drug that has been used for over 40 years by medical personnel and is available by prescription in conjunction with medical care. She turned her time over to Director Elisha Figueroa.

Elisha Figueroa, Executive Director of IODP presented Idaho-specific data regarding naloxone. She said in 2012 Idaho ranked 4th in pain medication abuse (SAMHSA, 2012). Since 2000, Idaho treatment centers have seen a 7 times increase in percent of opiate primary substance abuse admissions (SAMSHA, TEDS 2000-2010). Since 2000, Idaho has experienced a 250 percent increase in drug induced deaths (Idaho Vital Statistics, 2000-2010).

Director Figueroa said that according to the World Health Organization (WHO), increasing the availability of naloxone could prevent more than 20,000 deaths in the United States each year. According to the Centers for Disease Control and Prevention (CDC), in a 2012 survey of 329 drug users, 64.5 percent had witnessed an overdose and 34.6 percent had unintentionally overdosed. A 2008 study concluded that, after receiving basic training, lay people did just as well as medical professionals in recognizing the symptoms of an overdose and determining when to use the medication.

Director Figueroa said a concern has been when someone is suddenly brought out of an overdose state, it is uncomfortable or painful. Sometimes they don't react well and they can become aggressive. In research studies the IODP found that 1 in 453 people became aggressive 10 minutes after the administration of naloxone, after which no further complications existed. With those kinds of statistics, they feel the benefits outweigh the risks.

Director Figueroa reported that the Idaho Academy of Family Physicians, AMA, Office of National Drug Control Policy, National Association of State Alcohol/Drug Abuse Directors, and the WHO are all in favor of improved access to naloxone. She said 23 states and the District of Columbia have similar laws to increase access and defuse liability fears. The states are New York, Illinois, Washington, California, Rhode Island, Connecticut, Massachusetts, North Carolina, Oregon, Colorado, Virginia, Kentucky, Maryland, Vermont, New Jersey, Oklahoma, Utah, Tennessee, Maine, Georgia, Wisconsin, Ohio and New Mexico.

Director Figueroa closed with a quote from the Network for Public Health Law: "Since such state laws have few if any foreseeable negative effects, can be implemented at little to no cost, and will likely save both lives and resources, they may represent some of the lowest hanging fruit available to public health policy makers today." **Director Figueroa** stood for questions.

Senator Hagedorn asked if Director Figueroa was aware of any negative impacts in other states. **Director Figueroa** said she has not heard any negative feedback from the 23 states that have passed the laws. She had asked the participating states surrounding Idaho if they had seen a significant increase in their Medicaid costs. Washington was the only state responding so far, and they have not seen a significant increase.

Senator Nuxoll asked Director Figueroa how people get a prescription for naloxone, and how they would know when to administer it. **Director Figueroa** said if a person suspects one of their family members is abusing opioids, they can go to their physician and get a prescription for themselves to get naloxone to keep on hand in case of an emergency. Or a person can go to a pharmacy, talk with the pharmacist and have a prescription for naloxone given to them if they have a family member who is on opioids for chronic pain after a surgery. Learning how to recognize someone in an overdosed state would be incumbent on the consumer. Administering naloxone buys time to get folks to emergency services.

Senator Lee asked about the safety of the medication. She said other states have adopted policies that make naloxone not a prescription. She asked Director Figueroa's opinion on whether naloxone should be available over-the-counter.

Director Figueroa clarified that the bill gives another option of going straight to the pharmacy instead of going to their physician. She said it needs to be a prescription to be covered by Medicaid and other insurance plans, so that could be a cost savings. She said more information about the scheduling can be provided by Mark Johnston of the Board of Pharmacy (BOP).

Melanie Curtis, Executive Director of Supportive Housing and Innovative Partnerships (Partnership), spoke in support of **H 108**. She said she has been doing safe and sober housing for 14 years. The Partnership has a contract and grant with the Veterans Administration (VA) to provide housing and wraparound services for veterans. Since it is not legal in Idaho for the Partnership to get it, she is in a quandary. The VA is going to require the Partnership to have it at their four VA-exclusive houses. **Ms. Curtis** is also the mother of a child who died of a prescription overdose. If she had known about naloxone, she feels she could have saved him. She said it would work well to make naloxone available through pharmacists, because the Federal Drug Administration (FDA) has determined it is a prescription drug and it can not be distributed over-the-counter until the FDA changes that.

Michele McTiernan-Gleason, Director for Recovery Wellness for Connect the Pieces, spoke in support of **H 108**. She said passing **H 108** in Idaho is a common sense intervention that could save lives and help to bring the drug epidemic under control.

Mark Johnston, Executive Director, BOP, spoke in favor of **H 108**. He said the Office of the Attorney General, with Health and Human Services and the Drug Enforcement Agency (DEA) have designated naloxone as a prescription item. When the BOP first looked at it they thought they would make naloxone an over-the-counter drug, but it quickly became apparent they could not be more lenient than the federal government.

Senator Lee said she saw that CVS has 63 pharmacies in Rhode Island that approved naloxone to be over-the-counter. **Director Johnston** said in Rhode Island they have a practice in pharmacy called a collaborative practice. It's a contract where a physician or a group of physicians give a pharmacist or a group of pharmacists some of the physicians' rights. That's what they did in Rhode Island. A physician granted all the CVS pharmacies the ability to dispense naloxone. **H 108** gives the pharmacist the authority to prescribe and dispense at the same time without having to bother with the contract to form a collaborative practice agreement. It gives Idaho a little more freedom than what happens in Rhode Island. He said Idaho pharmacists already have prescriptive authority for immunizations and dietary fluoride supplements in certain circumstances.

Senator Schmidt asked Director Johnston if there was consideration given to adding naloxone to the prescription monitoring program. **Director Johnston** said the BOP did not have that conversation because it would take a statutory change. The BOP only has statutory authority to collect data on dispensed controlled substances and naloxone is not a controlled substance.

Senator Lee asked if there are other similar practices or medications where a person can obtain a prescription for someone else's benefit. **Director Johnston** said as of a bill from last year, schools have the ability to obtain epinephrine (EpiPen), and someone who is trained within the school can use it on any child that has an allergic food reaction in the school. The precedent has been set where the prescription drug is labeled in one person's name but legally able to be administered to a separate person.

Senator Schmidt said the use of an Automatic Electrocardio Defibrillator (AED) is a specific treatment for a specific condition, and it is non-prescription.

Ryan Buzzini, Law Enforcement Officer, Boise Police Department, spoke on his own behalf in support of **H 108**. He said he has been investigating pharmaceutical fraud cases for 20 years. A vast majority of the cases involved narcotic analgesics (pain pills) as well as heroine. He said typically when people stop or cannot get pain pills from the doctor's office, they switch to heroine.

Officer Buzzini said in rural areas where emergency medical service (EMS) is not readily available, naloxone could save lives and also save health care costs down the road. He related that four to six minutes after respiratory depression, hypoxia sets in. When hypoxia sets in, a person goes into a persistent vegetative state where they may end up on a ventilator, perhaps in a hospital bed for many years, increasing health care costs for long-term care significantly.

Senator Hagedorn thanked Officer Buzzini for his service and asked him if naloxone is injectable or a pill. **Officer Buzzini** said it comes in an intra-nasal spray which is shot into the soft tissue of the nose where it gets absorbed. It also comes as an intramuscular injection. A medical professional may dispense it through an intravenous line (IV), however that is not a part of **H 108**.

Todd Palmer, M.D., said he teaches at Family Residency Medicine of Idaho, is in charge of the addiction medicine curriculum there and has been involved in addiction medicine for years. He said prescription drug addiction is truly a major epidemic. In the 1990s doctors were criticized for not treating pain adequately, and now the pendulum has swung too far the other direction. The U.S. has 5 percent of the world's population and consumes 80 percent of the world's opiates. He said people can overdose in different scenarios. Sometimes doctors miscalculate when switching a patient from an IV in the hospital to orals at home. One good example is methadone which takes about a week for the full pain-relieving effect to occur. Respiratory suppression side effects occur quicker. A physician who is not totally aware of this may over-prescribe methadone if a patient calls him in a lot of pain. If the doctor increases the dose too soon or too much, the patient may die in their sleep from respiratory arrest. That is one example where naloxone will be life-saving. The other is with addicts. He said many people whose lives were normal until they got into a pain syndrome are prescribed narcotics and sometimes get addicted. Along the way, it would be nice to have a drug their family or they themselves could use to save their life if they miscalculate. **Dr. Palmer** said he strongly supports **H 108**.

Representative Perry closed by saying **H 108** is supported by the IDOP, the Idaho BOP, the Idaho State Pharmacy Association, and the Idaho Retail Association as well as all the people who spent their time to come today. There has been no opposition to the bill. They had no trouble on the House side. She thinks it is a great way to access and leverage their resources. She said pharmacists are a great resource and this will be a way to help them save lives. She thanked the work group and everyone who put effort into the bill, and she asked the Committee to send **H 108** to the floor with a do pass recommendation.

MOTION: **Senator Nuxoll** moved to send **H 108** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion. The motion passed by **voice vote**. Senator Tippetts will carry the bill on the floor.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:08 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Paula Tonkin
Assistant Secretary

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, March 05, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for January 22, 2015	Senator Schmidt
	Approval of the Minutes for February 5, 2015	Senator Lacey
	Approval of the Minutes for February 9, 2015	Senator Nuxoll
	Approval of the Minutes for February 10, 2015	Senator Lee
<u>H 177</u>	RELATING TO MINORS - Amend to prohibit the use of tanning devices on minors except in certain situations	Emily McClure

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Lacey

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, March 05, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Nuxoll, Hagedorn, Tippetts, Schmidt, Jordan and Lee

ABSENT/ EXCUSED: Senators Lodge

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:19 p.m.

MINUTES APPROVAL: **Senator Schmidt** moved to approve the Minutes of January 22, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Lacey** moved to approve the Minutes of February 5, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Nuxoll** moved to approve the Minutes of February 9, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

H 177: **Relating to minors; amending section 18-1523, Idaho Code, to prohibit the use of tanning devices on minors except under certain circumstances;** presented by **Emily McClure**.

Emily McClure, Idaho Medical Association (IMA), said **H 177** amends Idaho Code § 18-1523d to include a restriction on the use of tanning beds by minors. In May 2014, the federal government mandated a black box warning label be affixed to tanning beds stating tanning beds should not be used by people under the age of 18.

Dr. Steven Mings, dermatologist, Boise, said **H 177** introduces parental consent for adolescents between the ages of 14 and 18 and bans use by minors 13 and under. It includes a provision for medically helpful usage by children 13 and under. He stated the evidence against artificial tanning by minors was clear; it has been proven to cause cancer. **Dr. Mings** said a restriction on adult usage was not the intent of the bill; it was to protect minors against misuse of ultraviolet light leading to an unnecessary risk of skin cancer. **Dr. Mings** told the Committee Idaho's occurrences of skin cancer and skin cancer related deaths are among the highest rates in the nation.

Senator Hagedorn asked if children's skin was more susceptible to skin cancer than adults and if the energy level produced by tanning beds was higher than the sun's levels. **Dr. Mings** said the sun and tanning beds were equally strong. He said skin cancer has been shown to have a definitive link to childhood exposure that does not diminish with age.

TESTIMONY: **Dr. Paul McPherson**, pediatrician, Idaho Chapter of American Pediatrics (ICAP), expressed ICAP's support for **H 177**. He stated a survey of high school students indicated 32 percent of 12th grade girls admit to the use of tanning beds. **Dr. McPherson** said enacting regulations on the use of tanning beds for minors would help to stem unnecessary risk of future skin cancer and immediate consequences such as tanning bed burns.

Robin Martin, Sole Survivor Melanoma Support Group (SSMSG), said she was a two time skin cancer survivor; her tanning began as a teenager in an attempt to fit in. **Ms. Martin** gave support for **H 177**.

Senator Hagedorn asked if Ms. Martin's mother was aware of the risk for skin cancer when her mother allowed her to use tanning beds during her teenage years. **Ms. Martin** replied little was known regarding the risk of skin cancer and its link to tanning beds during the late 1980s and early 1990s.

Stacey Satterlee, American Cancer Society (ACS), Cancer Action Network (CAN), said ACS could not support **H 177** because it does not fully ban all minors from the usage of tanning beds. The compromised bill was a good step toward initiating awareness of the dangers caused by of tanning bed usage. **Senator Tippetts** asked Ms. Satterlee to clarify her position of not supporting the bill on the basis it was not a complete ban on minors. **Ms. Satterlee** stated the national organization's position was to see a full ban. She said her personal opinion was the bill sent a strong message about the dangers of tanning beds.

Courtney Knudsen, SSMSG, expressed her support for **H 177** as she was a skin cancer survivor who was a teenage user of tanning beds. She said a bill enacting parental consent would have prevented her early usage of tanning beds.

Ms. McClure informed the Committee that **H 177** passed the House committee and House floor. **Vice Chairman Martin** asked about the content of the previous failed versions of this bill. **Ms. McClure** said the 2012 version was a full ban on usage of tanning beds by minors; 2013 included parental consent for minors ages 16 and 17, with a full ban under 16. **Chairman Heider** added in 2012, experts were evenly divided at the time about the risk to minors. **Vice Chairman Martin** asked about the age restrictions written in Idaho Code § 18-1523. **Ms. McClure** said under the existing code, children between the ages of 14 and 18 need parental permission for such activities as body piercings and tattoos, which are banned for children 13 and under. **H 177** would add artificial tanning through the use of tanning beds to the existing code.

Vice Chairman Martin inquired who was guilty if Idaho Code § 18-1523 was violated. **Ms. McClure** stated under the code, any person who knowingly allows or facilitates the activity to occur upon a minor. **Senator Hagedorn** asked since this statute was added in 2004, how many people have been convicted under this code. **Ms. McClure** said her research indicated no prosecutions had occurred under this code.

MOTION:

Senator Martin moved to send **H 177** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion.

Senator Nuxoll said education and awareness of the link between skin cancer and tanning beds was of primary concern. She said a concurrent resolution would be the most appropriate course of action for this issue since it would not impose upon the rights of parents. **Senator Nuxoll** said she did not support the bill.

Senator Lee said this bill allowed parents the ability to determine the best course of action for minors in a high risk activity. She gave her support for this bill.

Chairman Heider called for a roll call vote. **Chairman Heider, Senators Martin, Hagedorn, Tippetts, Lee, Schmidt** and **Lacey** voted **aye**. **Senator Nuxoll** voted **nay**. The motion carried.

**MINUTES
APPROVAL:**

Chairman Heider stated there was one more item on the Agenda; the approval of the Minutes of February 10, 2015 by Senator Lee. **Senator Lee** expressed apologies for not being present in the beginning but had reviewed the Minutes for February 10, 2015, found them to be in good order, and moved for a motion to approve. **Senator Tippetts** seconded the motion. The motion carried by **voice vote**.

ADJOURNED:

There being no further business, **Chairman Heider** adjourned the meeting at 4:11 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jenny Smith
Assistant Secretary

AMENDED AGENDA #3
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Monday, March 09, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for January 15, 2015	Senator Martin
	Approval of the Minutes for February 16, 2015	Senator Schmidt
RS23792	REQUEST FOR UNANIMOUS CONSENT FOR RS23792 to be heard in Privileged Committee - Relating to language corrections	Chairman Heider Lee Flinn Advocacy Director, AARP Idaho
H 150	RELATING TO MEDICAL LICENSURE - Interstate Medical Licensure Compact	Rep. John Rusche Nancy M. Kerr M.Ed.,RN,CMBE Executive Director
H 189	RELATING TO TELEHEALTH SERVICES	Rep. John Rusche

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider	Sen Tippetts
Vice Chairman Martin	Sen Lee
Sen Lodge	Sen Schmidt
Sen Nuxoll	Sen Lacey
Sen Hagedorn	

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
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MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, March 09, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** welcomed everyone. He introduced Senator Maryanne Jordan who was attending for the first time. He welcomed her to the Health and Welfare Committee (Committee).

MINUTES APPROVAL: **Vice Chairman Martin** moved to approve the Minutes of January 15, 2015. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Schmidt** moved to approve the Minutes of February 16, 2015. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

UC REQUEST: **Chairman Heider** asked for unanimous consent to send **RS 23792** to a privileged committee for a print hearing.

RS 23792 had previously been sent to print, but Senate Leadership asked for a change in the fiscal note. It will state "that any advisors to the task force who are not legislative members shall not be reimbursed from legislative funds for per diem, mileage or other expenses and shall not have voting privileges." This is the standard for an interim committee.

There were no objections.

H 150 **Representative Rusche** began his presentation by stating the purpose of **H 150** is to provide an expedited medical licensing process that preserves the State Board of Medicine's function in controlling medical licenses. This legislation is for a component agreement between states and was developed by the Federation of State Medical Boards and the Council of State Governments. The home state examines the background information, curriculum vita and the diplomas, but each state issues its own license. The legislation provides definitions and procedures for licenses and renewals, provides for a coordinated physician information system, and allows joint investigations. While each individual board disciplines the licensees in their state. Rules regarding how member states exist with each other and how to withdraw from the compact are proposed. The compact is currently being formed, and people who are early in the process get to help define what the rules are going to be.

Chairman Heider asked Nancy Kerr to give her presentation.

Nancy M. Kerr, Executive Director of the Idaho Board of Medicine, began her presentation by stating that a compact is basically a contract between compact states. They are constitutionally authorized and retain state sovereignty on issues traditionally reserved for state jurisdictions. Idaho is currently a part of 26 interstate compacts. The need for license portability facilitates multi-state practice without compromising patient safety or quality. Less than half of Idaho's physicians are currently licensed in more than one state. There is a federal push going on right now to nationalize all forms of health care licensure. One of the ways Idaho can ensure that it retains its authority to regulate its own physicians is through the use of a compact versus a federal law. Participation in a compact is voluntary. This legislation would affirm that the practice of medicine occurs where the patient is located not where the physician might be calling in from. Others allow improved sharing of complaints and investigative and licensure information between medical boards. It sets a high bar for physicians applying for a license under the compact. The compact becomes a coordinated information system establishing a database of all physicians who apply or are licensed through compact. Under the compact, Idaho would have subpoena authority to investigate physicians in other member states. State boards retain licensing authority and participate as commission members. It is not expected that the budget to operate this program would be substantial. Each member board retains its own licensing fees.

Some of the misconceptions are that the compact overrides the State's authority to license and regulate physicians; it does not. It is not difficult to get out of a compact. It will not increase the cost to the State and licensee because it will reduce paperwork, administrative processing time and related issues. The definition of a physician does not change in a compact. The benefits would include telemedicine expedited processes, locum tenens with coverage for hospitals, specialty consultations, physicians who are able to practice and apply for privileges in shorter time, and creates a potential for attracting new physicians. By joining the compact, the initial states involved will be the states that establish the rules and fees for the compact, and all states will have two votes. Compact programs have endorsements from national and regional organizations including the American Medical Association and the Mayo Clinic (see attachment 1).

Chairman Heider asked for questions.

Vice Chairman Martin asked whether there was a difference in an Idaho license and a compact license as far as the information required to apply for such licenses.

Ms. Kerr stated that the physician would apply in their principle state, and if compact states had additional requirements, then they would be required to complete those. **Vice Chairman Martin** asked if Idaho went into the compact, would Idaho's licensing process change. **Ms. Kerr** stated that it would not unless the compact added another requirement at a later time.

Senator Nuxoll asked if there was a goal beyond the compact. **Ms. Kerr** stated that federal law requires seven states to sign on to have legislation and then it has to go to Congress. There are currently 27 states. **Senator Schmidt** asked if this process was similar to other states that have already passed the process or would Idaho have to write its own process. **Ms. Kerr** responded that this compact is the same legislation used in other states. She indicated that this compact content is most closely tied to the Nursing License compact.

Susie Pouliot, Idaho Medical Association, testified in support of this Legislation for all of the reasons that had previously been stated. She was also very supportive of Idaho joining in the compact at this time because it will enable Idaho to be a very influential member.

Chairman Heider referenced telemedicine and asked if this would allow Idaho to communicate directly with the Utah Burn Center via telemedicine. **Ms. Pouliot** indicated that physicians who reside in a state that is a member of the compact would be able to use telemedicine to treat Idaho residents. This would expedite that process.

Senator Hagedorn asked how and what process would allow the out of state physicians who are licensed through the compact to have access to the health medical record exchange. **Ms. Pouliot** suggested that someone more knowledgeable in that area answer that question. **Representative Rusche** indicated that these aren't differently licensed physicians. They have the same medical license as physicians in Idaho. The mechanism for practicing in multiple states is expedited in a more efficient manner. He went on to state that physicians have practices that cross state borders, and they want to have a mechanism for quickly becoming licensed in the neighboring states. Telemedicine is going to play a role in future services, and centers are going to make specialty services available.

Senator Hagedorn questioned what would happen if a doctor was indicted for an infraction and asked how the that Board would be notified. **Representative Rusche** stated that much of that procedure would be covered in the rules of the compact. The one exception was that if the license in the home state was revoked, then that revocation would spread throughout the system. The Board of Medicine action is what flows through the compact states, not any type of criminal action.

Chairman Heider thanked Representative Rusche for his presentation.

MOTION:

Vice Chairman Martin moved to send **H 150** to the floor with a **do pass** recommendation. **Senator Nuxoll** seconded the motion. The motion passed by **voice vote**.

H 189

Representative Rusche presented **H 189** relating to telehealth services. Telehealth will improve access in Idaho and especially in rural Idaho. Telemedicine and telehealth services have grown over the last few years. An industry work group was started two years ago with about eight people. At a meeting held last summer, there were over 80 people and organizations who were signed up. They found incredible interest in telehealth and telemedicine. Some barriers included regulation, what is telehealth (how do we know it when we see it), what constitutes the right kind of care, training, payment and whether there are available technologies in rural areas to use these tools. One of the themes of the legislation is to separate the health care practice from the technology and establish some commonalities between provider licensing boards. This bill is trying to provide a framework that all health care licensing boards could use. A few important points in the bill include the definition of what a provider/patient relationship is, prescribing drugs through telecommunication within the license that someone holds, and addresses for maintaining records. The individual licensing boards would enforce this law. It establishes a uniform framework in which any healthcare licensing board in Title 54 can define and use telehealth for their profession.

TESTIMONY:

Stacey Carson, Vice President of Operations at the Idaho Hospital Association, testified on behalf of the Idaho Telehealth Council (Council), in support of **H 189**. **Ms. Carson** began by describing the membership of the Council. The Council has been meeting regularly since July and has spent many hours putting together **H 189** as it currently stands. Telehealth plays a vital role as Idaho strives to achieve the triple aim to improve: 1) quality of care; 2) population health; and 3) affordability of health care. Health care providers need clear guidance for delivering care using telehealth in Idaho, and patients need to know they can trust the care they receive via telehealth. She went on to describe the highlights of the bill (see attachment 2).

Chairman Heider thanked Ms. Carson for her testimony and asked for questions. There were no questions. **Chairman Heider** indicated Nancy Kerr would testify and asked her to introduce herself.

Nancy Kerr, Idaho Board of Medicine (Board), said that the Board participated on the Council and supports **H 189** for all the reasons previously mentioned. **Senator Schmidt** asked what the definition of "appropriate" meant in relation to the provider/patient relationship. **Ms. Kerr** stated that appropriate care is defined as the Idaho standard of care. Regardless of the method of delivery, care must be the same as that for an in-person visit.

Chairman Heider thanked Ms. Kerr for her comments.

TESTIMONY:

Adam Husney, board certified family physician and Director of Urgent Care, St. Alphonsus Medical Group, indicated he had been actively involved in electronic visits at St. Alphonsus. He stated that he believes telehealth would help accomplish the triple aim of improving outcomes, lowering health care costs and improving patient satisfaction. Telehealth allows remote access to improve acute care. In situations where seconds matter, decisions about how to treat patients can be very difficult and risky. Having immediate access to health care gives the patient real time access to the highest level of care. In outpatient care, evidence shows that mental illness is a big player in chronic disease, and access to the right care can ease the burden of that disease by improving the quality, lowering costs and decreasing morbidity. Telepsychiatry can provide access where it is not traditionally available. There are many outpatient conditions that can be successfully treated using the best medical evidence through telehealth. This can be done with greater standardization, significantly lower costs, and equivalent or better outcomes than come with a traditional office visit. The goal is for providers to use the best technology available to improve the care of patients. To ease the transition to telemedicine, clarity on the State's policy related to telehealth through this bill is needed to ensure providers understand rules related to practicing medicine, using telehealth, and to ensure that patients have the confidence that care delivered by telehealth is safe and secure. The tools are changing and this legislation would provide guidance on how to use them.

Senator Hagedorn asked if Dr. Husney handled hospital privileges for those that provide telehealth services differently than hospital privileges for a doctor who wants to work in a hospital. **Dr. Husney** responded that there would be no difference in the way they are setting up the program now. The requirements to become a St. Alphonsus doctor are the same ones that allow them to participate in their telehealth program. **Senator Hagedorn** asked if hospital privileges are defined by each individual hospital. **Dr. Husney** stated that they were.

Chairman Heider thanked Dr. Husney for his testimony and asked Paul McPhearson to introduce himself.

Dr. Paul McPhearson, board certified pediatrician, St. Lukes Children's Hospital, indicated that he was a member of the Telehealth Council who drafted this proposal and a representative of the Idaho Academy of Pediatrics. He spoke about the telehealth bill relating to pediatrics. Passage of this bill would allow a more robust telehealth program in the State of Idaho and allow the pediatricians with subspecialty training to access children in rural Idaho. He had done research over a 10 year period of 46 articles, and the majority demonstrated an important benefit and outcome in the health and care of the patients. In December 2014 at a National Endocrinology Conference, data was presented from a children's hospital in Colorado. Their study covered teenagers from the Cheyenne and Casper region who were receiving care for Type I diabetes in the center at the University of Colorado. For about a 15 month period they were evaluated by telemedicine. They discovered that 97 percent of the families that participated were either

satisfied or highly satisfied with their experience. Regional data that represented positive outcomes for telemedicine both in terms of patient care, patient and family satisfaction, and decreased work and school absences were documented. The opportunity to codify telehealth in Idaho laws is an important next step to developing sustainable models to improve the health of the people of Idaho.

Chairman Heider asked for questions and thanked Dr. McPhearson for his testimony. He asked Molly Steckle for her comments.

TESTIMONY: **Molly Steckle** indicated she was in complete support of all that had been said in prior testimonies.

Representative Rusche concluded by saying that telehealth is going to happen. Idaho has an opportunity to organize and facilitate that transition. This is a platform and framework in which the various boards can assist the development of their practitioners with safe and reasonable precautions and allow them to grow the practice in the State of Idaho. **Representative Rusche** asked for questions.

MOTION: **Senator Lodge** moved to send **H 189** to the floor with a **do pass** recommendation. **Senator Nuxoll** seconded the motion.

Vice Chairman Martin referred to page 3, lines 30 and 31, and asked to have those lines added to the bill. **Senator Jordan** stated that she feels the technology is a good thing for rural Idaho. She was concerned about lines 20 and 21. She felt they placed undo burden on women in rural areas. Her concern was that those women may be denied an opportunity to have access to their doctors.

The motion passed by **voice vote**. **Senator Jordan** requested that she be recorded as voting nay.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:30 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Assistant Secretary

Testimony – March 9, 2015 – H189

1. Mr. Chairman and members of this Committee – my name is Stacey Carson and I am vice president of operations at the Idaho Hospital Association. I am here today on behalf of the Idaho Telehealth Council of which I currently serve as chairman. I appreciate having the opportunity to testify today in support of House Bill 189.
2. Last year the Idaho legislature passed House Concurrent Resolution 46 and the Idaho Telehealth Council was convened to coordinate and develop a comprehensive set of standards, policies, rules and procedures for the use of telehealth and telemedicine in Idaho. The governor-appointed Council is comprised of (5) physician/provider representatives (including the IMA), (6) hospital representatives (including the IHA), (7) payer representatives, (2) regulatory agency representatives (including the Idaho Board of Medicine), (1) public health representative (Bureau of Public Health), and a representative from the Idaho Primary Care Association.
3. The Council has been meeting regularly since July. House Bill 189 is a result of many hours of work by members of this Council which included a comprehensive review of policies from many other states and examination of guidelines offered by standard setters such as the American Telemedicine Association and the Federation of State Medical Boards. I might add that during this exercise we learned that many states are doing similar policy work to ensure the safe use of telehealth in practice. The Council took great care to balance IMPROVED ACCESS TO HEALTHCARE with PATIENT SAFETY. After many drafts, an attorney review process, and vetting with many stakeholders, the Council has taken a position of support on H189.
4. Telehealth plays a vital role as Idaho strives to achieve the triple aim to improve: 1) quality of care; 2) population health; and, 3) affordability of healthcare. The appropriate use of telehealth technologies offers healthcare providers, hospitals, and health plans ways to provide improved access to healthcare. Telehealth can deliver safe, secure and cost saving access to healthcare for Idahoans and can bring care into clinical as well as non-clinical settings. Telehealth helps address barriers to access due to provider shortages, improves access to specialty physicians, and can keep care closer to home. Despite healthcare provider shortages, providers are sometimes reluctant to practice using telemedicine technology in Idaho and payers are reluctant to reimburse due to unclear policy.

5. Healthcare providers need clear guidance for delivering care using telehealth in Idaho and patients need to know they can trust the care they receive via telehealth is safe and secure. Patient safety has been paramount to the Council members as we acknowledge the opportunities and the impact technology has had, and will continue to have, on the practice of medicine and the delivery of healthcare services in Idaho.
6. The main highlights of the Act include the following elements:
 - Patient-provider relationships can be established without an in-person visit using two-way audio and video and maintained using electronic communications (phone, email, etc);
 - Prescription drug orders can be issued using telehealth services with some parameters;
 - The bill Increases access to healthcare while enabling providers to deliver safe & high quality care;
 - The bill promotes continuity of care and requires providers to obtain a good medical history and adequate documentation that is secure and available to the patient and other providers.
 - The bill supports multi-disciplinary collaboration such as patient-centered medical homes.
 - Telehealth services can be delivered within the provider's scope of license and consistent with the current standards of care.
7. In summary, I thank you for the opportunity to provide an overview of the Idaho Telehealth Council's work and testimony in support of House Bill 189.

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, March 10, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of Minutes for February 17, 2015	Senator Hagedorn
	Approval of Minutes for February 19, 2015	Senator Nuxoll
<u>H 178</u>	RELATING TO HEALTHCARE - Rural Physician Debt Program	Susie Pouliot , CEO Idaho Medical Association

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider	Sen Tippetts
Vice Chairman Martin	Sen Lee
Sen Lodge	Sen Schmidt
Sen Nuxoll	Sen Jordan
Sen Hagedorn	

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, March 10, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Hagedorn, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: Senators Lodge, Nuxoll and Tippets

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.

MINUTES APPROVAL: **Senator Hagedorn** moved to approve the Minutes of February 17, 2015. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.

Chairman Heider postponed the approval of the Minutes of February 19, 2015, to a future meeting.

H 178

Susie Pouliot, CEO of Idaho Medical Association (IMA) and a member of the board of the Rural Physician Incentive Program (RPIP), spoke in support of **H 178**. She said passage of the legislation would help cure the physician workforce shortage in Idaho.

Ms. Pouliot explained the physician workforce pipeline has three distinct parts: medical education, residency training, and recruitment and loan repayment. Thanks to the support of the Legislature, the IMA has succeeded in improving the first two parts of the pipeline by increasing the number of medical school seats available for Idaho students and expanding education and residency programs over the years. Physician loan repayment has been a weak link, and it has hurt Idaho's competitiveness in recruiting physicians to practice in Idaho.

Ms. Pouliot said passage of **H 178** would help bring more physicians to rural and underserved areas of the State. RPIP is currently funded by fees paid by medical students who attend the Washington-Wyoming-Alaska-Montana-Idaho (WWAMI) or University of Utah Medical Education Programs. No state funds are allocated.

- The annual fee per student is 4 percent of the state funding provided for each WWAMI or University of Utah student in state-supported states. For fiscal year (FY) 2015, Idaho is providing \$41,700 per student for these programs, and 4 percent (\$1,668) is going into the RPIP Fund.
- There are currently 117 students paying into RPIP, generating approximately \$191,000 per year.

She noted there is a provision in the law to allow local communities, hospitals, or other organizations to contribute to physician recruitment efforts, but no entity has taken advantage of the opportunity so far.

Ms. Pouliot said the existing eligibility and prioritization of funding provisions will stay the same.

RPIP eligibility requirements include:

- Must be a primary care physician in family medicine, internal medicine, pediatrics, or a demonstrated need in the area of OB-GYN, psychiatry, general surgery or emergency medicine.
- Must provide care in a medically underserved area or health professional shortage area.
- Must accept Medicaid and Medicare patients.

Applicants for RPIP funding must be, in priority order:

1. Idaho residents who attended WWAMI or the University of Utah and paid into the RPIP Fund.
2. Idaho residents who attended medical school in other states and did not contribute to RPIP.
3. Physicians from other states who aren't Idaho residents and did not contribute to RPIP.

Ms. Pouliot said physicians must provide documentation of their outstanding loan balance to ensure RPIP does not give an award that exceeds it.

Ms. Pouliot said the legislation would do three things:

- Double the amount of the awards over a 4-year period from the current \$12,500 per year (\$50,000 total) to \$25,000 per year (\$100,000 total).
- Increase the number of awards given by allowing the total awards to exceed the amount of fees being generated in a given year.
- Require the RPIP Board to maintain an appropriate fund balance in the account.

RPIP is not as effective as it could be because the current loan repayment limit of \$12,500 per year over 4 years is not as attractive as incentives from states with more robust funding and higher thresholds. For example:

- Oregon offers \$35,000 per year over 5 years (\$175,000 total).
- Montana offers \$20,000 per year over 5 years (\$100,000 total).
- Wyoming offers \$30,000 per year over 3 years (\$90,000 total).
- National Health Service Corps (NHSC) offers \$25,000 per year over 2 years (\$50,000 total).

Physicians are not eligible for Idaho's RPIP awards if they receive loan repayment from another state or federal program. Additionally, the NHSC and State Loan Repayment Program do not allow their recipients to participate in other loan repayment programs.

Ms. Pouliot said great resources are flowing in from medical student fees, but the funds are only trickling out to serve the recruitment and loan repayment needs. There are currently only 12 physicians in the program. A fund balance of approximately \$1.4 million has built up due to program constraints. She stood for questions and said Mary Sheridan was in the audience to answer questions as well.

Vice Chairman Martin asked what determines a rural physician. **Ms. Pouliot** said the United States Secretary of Health and Human Services has designated geographic locations by specialty for particularly underserved areas. **Vice Chairman Martin** asked what parts of Idaho are under this definition. **Ms. Pouliot** deferred to Mary Sheridan.

Mary Sheridan, Bureau Chief, Idaho Office of Rural Health and Primary Care (Bureau), Division of Public Health, said approximately 90 percent of Idaho is federally designated as a health professional shortage area in primary care. The only areas not eligible for this program are Ada and Blaine counties, so physicians in almost the entire state are eligible to apply.

Ms. Sheridan said RPIP was first established by Idaho Code in the Idaho Board of Education (BOE). The BOE was the recipient of the funds, but they did not have contact information for the physicians, so they asked the Bureau to implement the RPIP for them. The BOE receives the fees, deposits them into a trust, then the Bureau implements the program. She said it is a great partnership with a high-functioning board that is working well.

Senator Schmidt asked Ms. Sheridan what the increase in payments will do to the fund balance. He also asked if RPIP had a business plan. **Ms. Sheridan** said they have a big picture plan that shows at what point the balance will shrink the program. She said the RPIP Board will manage that, being careful not to grow the program too fast and create unrealistic expectations. **Senator Schmidt** asked if there are competing loan repayment plans and therefore a lack of eligible applicants. **Ms. Sheridan** said they have more applicants than they have been able to fund. Last year they had approximately 18 and they could only fund 4. The limitation, as the statute is written, is they cannot pay out more than they receive in a year. When they get to four or five, they start feeling uncomfortable because they are hitting the receipt point.

Chairman Heider commented that they will never draw down on the \$1 million principal if they cannot pay out more than they receive in a year. **Ms. Sheridan** said **H 178** strikes the limiting provision so they will be able to tap into the balance.

Ms. Pouliot closed by saying **H 178** will help recruit new physicians and retain Idaho-trained physicians by allowing a better outflow of funds and increasing the amount and the number of the loan payment awards. She thanked the Committee and urged them to approve **H 178**.

MOTION: **Senator Lee** moved to send **H 178** to the floor with a **do pass** recommendation. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:16 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Paula Tonkin
Assistant Secretary

AMENDED AGENDA #2
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, March 11, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for February 19, 2015	Senator Nuxoll
<u>H 107</u>	RELATING TO IMMUNIZATION ASSESSMENT BOARD	Rep. John Rusche
<u>HCR 9</u>	RELATING TO SOCIAL WORK RECOGNITION MONTH	Rep. John Rusche
<u>H 153</u>	RELATING TO EMERGENCY MEDICAL SERVICES	Rep. Luke Malek
<u>HCR 11</u>	RELATING TO RULE REJECTION/COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED	Rep. Fred Wood

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, March 11, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.

MINUTES APPROVAL: **Senator Nuxoll** moved to approve the Minutes of February 19, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

H 107 **Representative John Rusche** presented **H 107** relating to the Immunization Assessment Program (Program) that is run by the Vaccine Assessment Board (Board) of the Idaho Department of Insurance (DOI).

Representative Rusche said **H 107** extends the sunset date of the Board for two years from 2015 to 2017. He explained that before the recession, the State of Idaho got the lowest cost for vaccines by joining the federal vaccine purchase program called Vaccines for Children. In 2007, the state-funded program went away, so health insurance companies (carriers) and those who chose to use Vaccines for Children were facing a 30 percent to 40 percent increase in cost at the individual office level and increased complexity in doctors' offices by having to provide separate vaccines and billing procedures for Medicaid children, uninsured children and those who were insured commercially. A group of carriers, pediatricians and Legislators developed the Program as a way to purchase the vaccines at the lowest price possible. The Program collects an assessment from carriers to purchase the vaccine material. Last year, carriers paid \$19.3 million dollars for vaccines that would have cost \$25.6 million if purchased outside of the Program. This saved more than \$6 million. In addition, the single vaccine source allows improved efficiency and lower work requirements in the pediatricians' offices and health departments. The Board is asking for a two-year extension so that the transitions caused by the Affordable Care Act (ACA) coverage requirements can be observed and followed. He stood for questions.

Vice Chairman Martin asked Representative Rusche if the \$19 million that was paid by the State is reimbursed by the doctors or whoever is getting the vaccine. **Representative Rusche** said no, the carriers are paying for it. He said pediatricians cannot charge patients for vaccinations distributed through the Program. The pediatrician might charge for an office visit or for syringes and other equipment but not for the vaccine ingredient. The doctors also benefit by only maintaining one stock of vaccines instead of two that would get outdated twice as frequently causing loss of product and inventory. There is no cost to the State except approximately \$8,000 per year for the clerical cost of running the Board and sending out the bills to the various carriers. He felt that was a minimal amount to save \$6 million.

Senator Nuxoll asked Representative Rusche who pays the \$6 to \$7 million that is saved by the State. **Representative Rusche** responded that the savings are caused by the volume discount, so no one pays the \$6 to \$7 million.

Chairman Heider said it is significant that Tom Donovan from the DOI, Mitch Scoggins from the Department of Health and Welfare (DHW) and Kathryn Turner from Idaho Division of Public Health are all in favor of **H 107**.

MOTION: **Senator Schmidt** moved to send **H 107** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion.

DISCUSSION ON THE MOTION: **Senator Schmidt** said the situation was worse before the Program than Representative Rusche described. Physicians would have multiple stocks of immunizations in their refrigerators, they would have to give the right immunization to go with each type of insurance and Medicaid, and they had to bill differently for each. He said the Program has been a great benefit to primary care practitioners in the State.

Senator Nuxoll said she was glad there were benefits, however she had a problem with the compulsory payments required of the insurance carriers. **Representative Rusche** explained that all of the vaccinations are required to be first dollar coverage for all carriers because of the ACA. The carriers are saving about \$6 million per year, which they would have to cover if it were not for the Program.

VOTE: The motion passed by **voice vote**. **Senator Nuxoll** asked to be recorded as voting nay. Senator Schmidt will carry the bill on the floor.

HCR 9 **Representative Rusche** presented **HCR 9** recognizing social work. He deferred to Senator Cherie Buckner-Webb.

Senator Buckner-Webb said she was honored to present **HCR 9** for consideration as a proud member of the National Association of Social Workers (NASW). She explained it is a recurring concurrent resolution that is presented almost every year. She said social workers are an invaluable resource to communities across Idaho. Community intervention is a key tenet of social work practice: intervention in the life of a single client or a small, medium or large system. In the best of times social workers are called upon to intervene and to interrupt behaviors and systems that range from problematic to life threatening. Professional social workers are equipped to identify and manage these dilemmas. A social worker's primary responsibility is to promote the well-being of clients. They respect and promote the clients' right to self-determination and assist clients in their efforts to identify and clarify their goals.

Senator Buckner-Webb said the mission of the social work profession is rooted in a set of core values. Those values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective. The core values include service, social justice, dignity and worth of the person, importance of relationships, integrity and competence. She asked the Committee to support **HCR 9**, to proclaim the month of March 2015 as Social Work Recognition Month, and to call upon all citizens to join with the NASW in celebrating and supporting the social work profession.

MOTION: **Vice Chairman Martin** moved to send **HCR 9** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion. The motion carried by **voice vote**. Senator Buckner-Webb will carry the resolution on the floor.

Representative Luke Malek presented **H 153** relating to the Community Health Emergency Medical Services (CHEMS) Program. He said on February 25, Ada County Paramedics presented the concept to the Committee. This is the first of several pieces of legislation to be proposed over the next few legislative sessions. **Representative Malek** said **H 153** begins to build the foundation of the CHEMS Program that can be tailored to separate communities. He said there were members of the Ada County Paramedics and the DHW Bureau of Rural Health and Primary Medicine in the audience to talk about how important the CHEMS Program is and how it functions.

Senator Tippetts asked Representative Malek, since they were defining some terms that were not used in **H 153**, if the terms will be used in additional legislation. **Representative Malek** said that is correct. The definitions are meant to create a system that has not existed in Idaho Code before. He said **H 153** lays the foundation of the CHEMS Program for communities throughout the State. **Senator Tippetts** said it was difficult to assess whether the definitions were appropriate without seeing them in the context of either the rules or the statute. He asked if the terms will be used in statute, or in rules and statute, and why they were giving the definitions without the context. **Representative Malek** said the definitions are given in statute and will drive the rulemaking process. The rulemaking process will drive what the individual definitions mean to the communities.

Senator Schmidt said when he sees the term district he thinks of a taxing district. He asked if there would be an ability to levy taxes. **Representative Malek** deferred to the experts in the audience.

Darby Weston, Director of Ada County Paramedics, stood for the question. He explained that the inclusion of the language dealing with Title 31 and the ambulance taxing districts was to provide reference to Title 56 where the definitions and the authority to provide community health emergency medical services exists. It was to tie in the authority of the ambulance taxing district to provide community paramedic services specifically. It did not change the existing ability to levy taxes.

Director Weston said the reason they brought the legislation was to create within Idaho Code what they have learned from experience the last four years. For example, the definition of paramedic in Idaho Code was written for the emergent response and ambulance service. The definition of community paramedic was created in conjunction with the EMS Bureau because the definition that worked best in Ada County may not be the definition that would work best across the State. The EMS Bureau and the Idaho State Physician Commission for EMS will promulgate the rules and definitions. He said **H 153** sets up the framework to build the model across the State.

Vice Chairman Martin asked Director Weston what kind of services are provided when an ambulance is called in counties other than Ada County. **Director Weston** said there is something different going on in EMS in every community. Ada and Canyon are varied even though they use a lot of the same structures. **H 153** gives all systems the ability to provide proactive outreach, deliver community paramedic services in addition to their current services, and to leverage the infrastructure they have built. It has the same application whether an EMS taxing district, a fire district, a city or a private enterprise is providing this service.

Senator Lee asked if small rural ambulance districts will be able to meet the expectations to provide the types of service that would be required. **Director Weston** said it creates an opportunity. There are ambulance districts that can barely get enough volunteers to respond to emergencies. In those same communities, access to health care is probably in worse shape. The Program creates the opportunity to develop access to health care and outreach using the resources they have available and down the road, develop resources to increase the overall abilities of those systems. He said Mary Sheridan may be able to shed more light on how the State Healthcare Innovation Plan (SHIP) grant ties in for the rural areas.

Senator Tippetts said the new language on page 7, line 3, of the bill reads: "No act or omission of any person authorized under this chapter to provide community health emergency medical services shall impose any liability..." He asked who are the persons who are authorized. **Director Weston** said they are the people who have met the state requirements as promulgated in the rules to practice as a community EMT or community paramedic and are working for an agency designated as a CHEMS agency. The inclusion at that point in Idaho Code is to maintain the liability and risk profile that EMS currently has in providing the 911 response to the citizens of Idaho. The vast majority of what they do in Community Health EMS is in the same environment and context that they respond to today.

Chairman Heider asked Director Weston if the intent of **H 153** was to establish the definitions without establishing the department or means by which the definitions will be used. **Director Weston** said the intent was to create a place holder in Idaho Code for the EMS Bureau and the Physicians Commission to frame the rules around how they can and will be used.

Senator Tippetts asked if **H 153** grants any additional rulemaking authority that is not already available. **Director Weston** said no it does not. It simply provides direction to the EMS Bureau and the Physician Commission to promulgate rules around these new definitions.

Sean Rayne, Deputy Director of Operations, Ada County Paramedics, said part of his job has been overseeing the Community Paramedic Program for the past couple of years. He is in support of **H 153**. He said the program in Ada County has done some great things taking care of people who call 911 several times in a week. Instead of being reactive, the community paramedics go out and figure out what's going on with that patient and what they need to take care of themselves as opposed to relying on the 911 service to take them to the emergency room to figure out a simple problem. The community paramedic can educate and let the doctor know what is really going on in the house. They can do a medication reconciliation with the patient's physician to correct errors in dosages after patients return from the hospital with new medications.

Mr. Rayne said they had a meeting of the Community Paramedic Liaison Advisory Council where a group of stakeholders who are leaders in the health care industry in Ada County gathered to help steer the process. Mary Sheridan, Office of Rural Health, was there and gave a short presentation on the SHIP grant which contains the CHEMS Program. **Mr. Rayne** said he thinks **H 153**, with the definitions that are provided, fits nicely with the SHIP grant and the CHEMS Program. To answer Senator Lee's question, he said there may be some providers in the rural communities who aren't so interested in going out on the big wrecks and heart attacks, who may be at a point in their life where they would like to see patients in the middle of the day and take a proactive approach to keeping people out of the hospital and helping them become well. For example, in Custer County there is only one provider. There's no way that person would be able to do a bunch of house calls, but they might be able to leverage some resources. He stood for questions.

Senator Hagedorn asked if the definitions in **H 153** would assist the Ada County CHEMS in creating local ordinances or help the county itself create some of these services. **Mr. Rayne** said he did not think they would try to enact an ordinance, but it would allow them to take the concept they have been working on and move it toward a sustainable program and start looking at contracting with agencies to provide this service. He said at this point their legal services are uncomfortable that CHEMS may be putting Ada County EMS in a position of liability. Ada County EMS is statutorily obligated to provide 911 services, so if they go out and do something that isn't defined in law they could get themselves into legal complications that could cause them to stop providing 911 services.

Senator Schmidt said his home ambulance district is struggling with who pays for 911 services. He asked if the CHEMS program will change how billing is done and how taxing districts work. **Mr. Rayne** said he did not believe it would change the way they bill significantly. He sees some opportunity to tap into resources they have not been able to utilize up until this point. One of the concepts nationally is the idea of alternate destinations instead of the emergency department. He said there are talks of different types of models. Ada County CHEMS is looking at a program with St. Alphonsus Health Alliance for a capitation payment to go out and see 500 of St. Alphonsus' patients to do what may be needed to keep the patients out of the hospital. It is part of a grant from the Trinity Health Network, and they are still identifying metrics. As time goes on with this concept nationally, he thinks they'll see some of those models come to fruition along with some sources of payment they didn't realize before.

Mr. Rayne said when EMS goes on an ambulance call for a diabetic with low blood sugar, they put an intravenous (IV) line in the patient, put dextrose in the IV, wake the patient up, make the patient a peanut butter and jelly sandwich and give them a glass of orange juice. The patient does not need to go to the emergency department, they need to go to their endocrinologist or primary care provider instead. He said it is only about \$65 or \$70 for providing that service. The only payer that currently pays anything for that service is Medicaid. If EMS transports the patient to the hospital, even knowing they don't need to go, they get a full payment of \$600 or \$700. Talks are happening at a national level, as part of the EMS Field Bill that Senator Crapo is proposing.

Senator Nuxoll asked who will pay for the CHEMS Program expenses after the SHIP grant is gone. **Mr. Rayne** said Ada County is currently funding their own program. Last year they spent about \$280,000 and have not received much payment for it. The first inroad they are looking at is the St. Alphonsus Health Alliance capitation payment model. It will depend on each individual community and what resources they have available. He said Mary Sheridan can answer that question more appropriately about rural communities.

Senator Tippetts said he likes what they're doing, however he asked Mr. Rayne what **H 153** does beyond establishing some definitions that are not currently in the statute. **Mr. Rayne** said he believes the bill establishes the definitions, leaving them fairly open so the State EMS Bureau can make some rules that work for everyone in the State. **Mr. Rayne** said another idea he has heard is that it may enable a paramedic with some tenure to work for a rural provider, go out to see patients for the provider, be paid by that rural provider, and also be able to respond to 911 calls in an area that currently doesn't have a paramedic. **H 153** also helps with the liability piece to bring CHEMS under the current liability method as a 911 provider.

Senator Tippetts said that answer helped and asked Mr. Rayne to show language in the bill that enables the promulgation of the rules. **Mr. Rayne** said on page 7, Section 6, Legislative Intent, says it is the intent of the Legislature that the Idaho EMS Physician Commission and the EMS Bureau promulgate rules to govern CHEMS in Idaho.

Mary Sheridan, Bureau Chief of the Bureau of Rural Health and Primary Care (Rural Health Bureau), Division of Public Health, DHW, spoke about the connection between CHEMS and the SHIP plan. She said SHIP is a four-year model test grant the DHW has received from the Centers for Medicare and Medicaid Innovation. The grant started on February 1, 2015. The first year is a planning year, then there will be three years of implementation where they will test their innovations. The foundation of the SHIP grant is around primary care and the patient-centered medical home. They have included CHEMS within their SHIP grant initiative because they believe CHEMS will help alleviate the primary care shortage. They have proposed, under the SHIP grant, to fund education to support the new CHEMS programs in Idaho. The goal is three new paramedic programs per year for three years. They are also going to develop a CHEMS Program for basic life support (BLS) and intermediate life support (ILS) agencies using the SHIP grant funds. They think there is great alignment and think it will provide the framework to move the initiative forward in the SHIP grant.

Senator Hagedorn asked if she was on board with **H 153** as the framework to have this come about. **Ms. Sheridan** said absolutely. They see it as an expansion of the role of the paramedic and EMT. She does not envision needing to change scope of practice, but the EMS Physician Commission will take a look at that. They think it has been working well in Ada County, Bonner County and Teton County so they believe it's working under their current scope of practice.

Senator Nuxoll asked how it's working with rural districts and how they will keep paying for CHEMS if it is set up. **Ms. Sheridan** said their vision is to transform the health care system in Idaho from a value-based fee-for-service system to one that rewards outcomes over the course of the four-year SHIP grant. They are looking at things like care coordination and a tiered approach to paying for health care services for the patients in the medical homes or in the primary care clinics. They feel that by incorporating CHEMS within that effort, it will become sustainable as they evolve into a shared savings model. They have included a mentor program in the SHIP grant to tap into some experts who have built the CHEMS model and can help support the CHEMS programs in rural Idaho, looking at sustainability from the beginning. What they don't want to happen is simply creating another fee-for-service model for CHEMS. The whole initiative is aligned to improve population health, improve patient care and reduce costs. They believe as they evolve the payment system inclusive of CHEMS, they will sustain the program.

Representative Malek explained **H 153** is the foundation for the EMS Bureau to take the definitions and begin the rulemaking process. They are not asking for state funding. Whether SHIP funding is still available by the time the CHEMS Program is up in some of Idaho's communities is irrelevant. He said when it comes to funding, if it is not a sustainable program once it's built out, then it will be a failed project.

Senator Nuxoll asked if they would need to add many new employees for CHEMS. **Representative Malek** said this bill does not include that step, but there is that possibility. The project ultimately drives local control so it depends on what the localities want and have the capacity for. If they are able to bill Medicaid or other private payers along the line, yes they could absolutely add full-time employees; but not until that point.

Senator Tippetts said he likes the idea and wants to be supportive, but he wonders if the bill needs some amendments. **Senator Tippetts** asked Representative Malek to clarify the definitions of "community EMT" and "community paramedic." **Representative Malek** said Emergency Medical Technician is defined on page 5, line 32, of **H 153**. It is a term of art for purposes of this statute. A community EMT means the term of art EMT with additional standardized training. Paramedic is a term of art that is defined in **H 153** on page 6, line 3. Community paramedic means a paramedic with additional training. Again, that is a person who has met qualifications for licensure, is licensed by the Bureau, and carries out the practice of emergency care.

Senator Tippetts asked for clarification on who is authorized under this chapter to provide those services on page 7, line 3. **Representative Malek** referred back to the statutes he was just reading in terms of community EMT on page 4, lines 40 through 44, and community paramedic on page 5, lines 3 through 8. Those are the persons specifically authorized to provide those services.

Senator Hagedorn said he thinks **H 153** defines the foundation of a really good organizational opportunity. He added CHEMS is working in Ada County and two other counties that are much more rural than Ada County, and he thinks **H 153** defines the tools that local communities could use should they have the resources and need to use them.

MOTION: **Senator Hagedorn** moved to send **H 153** to the floor with a **do pass** recommendation. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**. Senator Hagedorn will carry the bill on the floor.

HCR 11 **Representative Fred Wood** said **HCR 11** was a rules rejection requested by the Office of the Governor and the Idaho Commission for the Blind and Visually Impaired (Blind Commission). The reason for the legislation was the Blind Commission had promulgated some rules last summer before similar federal rules came out. The Blind Commission's rules were not in compliance with some of the federal rules, therefore the Blind Commission was asking the House and Senate Committees to reject their prior rules so they may repromulgate and bring them back to the Committees again. He respectfully requested favorable consideration.

MOTION: **Vice Chairman Martin** moved to send **HCR 11** to the floor with a **do pass** recommendation. **Senator Lodge** seconded the motion. The motion carried by **voice vote**. Senator Lee will carry the concurrent resolution on the floor.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 4:18 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Paula Tonkin
Assistant Secretary

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, March 12, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
<u>RS23811</u>	REQUEST FOR UNANIMOUS CONSENT FOR RS 23811 to be heard in Privileged Committee - Related to Indigent Care	Senator Hagedorn
Presentation	Presentation on the National Alliance for Medicaid in Education (NAME)	John Hill Executive Director National Alliance for Medicaid in Education

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, March 12, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Vice Chairman Martin, Senators Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: Chairman Heider and Senator Lodge

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Vice Chairman Martin** welcomed everyone in attendance and convened the meeting at 3:05 p.m. He indicated that Chairman Heider was on state business and may or may not return for the meeting.

UC REQUEST: **Senator Hagedorn** asked for unanimous consent to send **RS 23811** to a privileged committee for a print hearing.

Senator Hagedorn indicated that the RS is basically the same bill that had been heard before about the Catastrophic Fund. He and Representative Trujillo worked on the language making it clearer. The meaning of the changed language is anyone that is above 139 percent of the poverty level will not be eligible for help through the Catastrophic Fund. **Senator Tippetts** stated that he would not object to this bill being sent to print, but he was not ready to support it. His action was in support of Senator Hagedorn's hard work on this bill.

There were no objections.

PRESENTATION: **John Hill**, Executive Director, National Alliance for Medicaid in Education (Board), began by describing the organizational makeup of the Board. The purpose of the organization is to better understand the federal and state reimbursement programs for Medicaid services that are delivered to students enrolled in public school special education programs. The mission of the organization is to advocate for the integrity of school-based Medicaid reimbursement. There are three areas of focus. The first is to work with federal partners at the Centers for Medicare and Medicaid Services in Washington, DC as well as the U.S. Department of Education. The second is to collaborate with the national partners in Washington, DC and around the country. The third is to facilitate a learning network. That is accomplished in ways such as an annual conference, topical calls for members around the country and informal information-based sessions. He indicated that this is the only place in the country where the sole focus is how to best work with the federal government and state agencies on implementing a program that maximizes the federal return at the same time minimizing audit exceptions occurring within the program.

Mr. Hill went on to say that each state has to make a policy decision on how and if they want to participate in the school-based Medicaid program. All 50 states participate to one degree or another, and his main interest was to see that participation is done correctly. If states don't use the federal money, they have to pay for the mandated services themselves. His interest is to make sure that the program is used to its potential without incurring audit exceptions. The Individuals with Disabilities Education Act (IDEA) requires school districts to meet the needs of special education students. Idaho's Medicaid reimbursement rate from the federal government is almost 72 percent, the second highest rate in the country. He was concerned that Idaho was spending \$20-40 million that they should not be. He shared experiences he saw during his work in Indiana.

Mr. Hill stated that all public funding has responsibilities attached. Three very basic ones include matching funds, working with local and state administrations and accurate reporting. States must recognize that these are services that have been previously delivered. States would be seeking reimbursement after the fact and reimbursement would be at about a 70 percent rate. States must decide to what degree they want to pursue maximizing these funds. A big deterrent to accessing these funds is that there are policies and standards that have to be followed. Audits have to be done, and as a result audit exceptions happen. There are three main reasons for that. The first is fraud. The second is someone billing for something that is not covered to their knowledge. The third is human error, someone mistakes a date or types an incorrect code. Idaho is one of two states that actually utilizes civil penalties against public school corporations when they are looking at audits. Schools need to do their due diligence so that they know what is going on in their districts as far as billing or not billing for eligible students and costs.

If Idaho decides to expand the program, it is very important that there is investment from both the Department of Education and the Department of Medicaid. Both need to be fully in support of the program and to share information. Training needs to be given and have evaluations after such training. Clear rules and expectations about who does and doesn't get Medicaid reimbursements need to be established. Determinations need to be made about service authorizations, medical provider credentials, and medical necessity issues. **Mr. Hill** recommended that if Idaho is going to expand the program, they should look at neighboring states to see how they set up their programs. Medicaid programs vary greatly from state to state. Children's needs are different from many years ago when the Medicaid program was first started. Federal and state regulations have forced schools to become medical providers (see attachment 1). **Mr. Hill** asked for questions.

Senator Tippetts asked what outcome **Mr. Hill** was hoping for after his presentation.

Mr. Hill responded that he hoped there would be a better awareness of the potential of the program. The goal of his organization is to see the program run effectively. **Senator Tippetts** asked who joins this organization and where the money comes from to support it. **Mr. Hill** said that anyone can join. Their Board is made up of state education staff, Medicaid staff, and school personnel from around the country, some professional organizations such as speech therapists, occupational therapists and other individuals. Their membership fees are \$50 annually, and other money comes from the annual conference. **Senator Tippetts** asked what incentive his organization had to send him here to talk to people in Idaho when Idaho's Health and Welfare Department is aware of this program. **Mr. Hill** stated that he was here by invitation from people in Idaho. **Senator Tippetts** said that his sources indicated that **Mr. Hill's** contact with Idaho Health and Welfare had been quite minimal. He asked why he hadn't just talked to them directly rather than coming to the Committee. **Mr. Hill** responded that he had a conversation with the State Medicaid Agency in August and had attempted to have a conversation with the State Department of Education and never got a response. Last week he had also tried to contact the State Medicaid Agency about his coming before the

Committee, and attempts to connect with them failed on both sides. Local school corporations had also contacted him and were concerned that they weren't getting the reimbursement they felt they should have. **Senator Tippetts** asked if there were Idaho school districts that were concerned that the State was not taking advantage of this program. **Mr. Hill** responded that was correct.

Vice Chairman Martin asked for other testimonies.

Dave Taylor, Deputy Director of the Department of Health and Welfare, began his comments by stating that the Department would be happy to present the history and progress that has been made over the past year in the Medicaid reimbursement area. He indicated that they had worked very closely with the Department of Education and had made a lot of progress. **Mr. Taylor** asked for questions.

Senator Hagedorn asked if Medicaid reimbursement was more of a Health and Welfare or a Department of Education issue. **Mr. Taylor** responded that they work very closely with the Department of Education. Regularly scheduled quarterly meetings with both the Department of Education and local school districts who are on the advisory board help to coordinate the program. There is also a person in Medicaid who is a direct liaison with the school districts to train and help them comply with the requirements. School districts become Medicaid providers, who have to comply with all the requirements of signing the agreement.

Vice Chairman Martin asked what Medicaid expansion has to do with this program. **Mr. Taylor** stated that the population that is already covered is not part of the GAP population. Those children would already have Medicaid coverage. **Vice Chairman Martin** asked what is currently a reimbursable item. **Mr. Taylor** responded that such items as speech pathology or physical therapy would be reimbursable.

Time was given to **Art Evans**, Bureau Chief of Developmental Services, Division of Medicaid, Department of Health and Welfare.

Mr. Evans began by stating that Idaho had 14 reimbursable services that schools can access and all are reimbursable under the current program. **Vice Chairman Martin** asked if there were federal mandated requirements in these areas or where the mandates were coming from. **Mr. Evans** stated that addressing IDEA was not his area of expertise. IDEA does require schools to provide a certain array of services regardless of where the funding comes from. IDEA mandates come from the federal government. **Vice Chairman Martin** asked what percent of the services provided are currently being reimbursed, and what percent of the schools were requesting reimbursement. **Mr. Evans** stated that Medicaid match is approximately 70 percent. Idaho has 174 schools districts and in 2014, 120 districts billed for Medicaid services. That expenditure totaled \$26.8 million.

Vice Chairman Martin asked for questions from the Committee.

Senator Lee asked what amount of money the State was not taking advantage of and why that was happening. **Mr. Evans** stated that he didn't have an answer for that. He had asked himself the same question. **Senator Schmidt** asked if any of the children were eligible for CHIP benefits. **Mr. Evans** stated that there were 202,000 children in the State of Idaho from birth to 18 years that qualify for some form of Medicaid. There are approximately 300,000 children in the school system and approximately 60 percent of them are eligible for some form of Medicaid.

Vice Chairman Martin asked for additional questions or comments from the audience or Committee.

ADJOURNED: There being no further business, **Vice Chairman Martin** adjourned the meeting at 3:40 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Assistant Secretary

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Lincoln Auditorium
Monday, March 16, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for February 2, 2015	Senator Tippetts
	Approval of the Minutes for February 12, 2015	Senator Tippetts
	Approval of the Minutes for March 3, 2015	Senator Lee
<u>H 181</u>	RELATING TO Naturopathic Medical Physicians Licensing	Chairman Heider

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, March 16, 2015

TIME: 3:00 P.M.

PLACE: Lincoln Auditorium

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:00 p.m.

MINUTES APPROVAL: **Senator Tippetts** moved to approve the Minutes for February 2, 2015 and February 12, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

H 181: **Kris Ellis**, on behalf of the Idaho Chapter of the American Association of Naturopathic Physicians (IDAANP), presented **H 181**. This legislation licenses naturopathic physicians who have gone to a four-year accredited school recognized by the Council on Naturopathic Medical Education (CNME). Their training includes traditional medicine and pharmaceuticals. They also take a nationally recognized multi-part exam. This legislation does not impact Chapter 51 in Idaho Code. The one-year grandfather clause allows prior graduates, who attended an accredited school and took the national exam, one year to become licensed. The fees, once determined, will fund a viable board. There is a 2021 sunset date. **H 181** expands the ability of the defined naturopathic physicians, without restricting or removing any rights to practice. Anyone allowed to practice under Chapter 51 is not in violation of **H 181** (see attachment 1).

Ms. Ellis said this legislation will help the public determine the practice category of a specific naturopathic's practice. Because previous attempts to include everyone into one board have been unsuccessful, this legislation delineates the two types of naturopathic practice and creates a second board. The board contained in Chapter 51 of Idaho Code will remain as it is. Further discussion referenced §§ 54-5601 and 54-5608 of Idaho Code (see attachments 2 and 3). This legislation requires licensure to use the title "naturopathic physician" or "doctor." The education includes a pre-medical undergraduate program, a four-year medical program, and a clinical rotation. The board would consist of one physician, one pharmacist, and three naturopathic physicians and shall establish by rule of formulary. The formulary will be determined by unanimous vote by the board. **Ms. Ellis** referenced § 54-5605 in regards to a current gap versus successful discharges; they are seeking the conformity that will close this gap (see attachment 4). Additional reference was made to § 54-5608 of Idaho Code, which states that qualifications are similar to other professions and protocols (see attachment 3). **H 181** includes language that is verbatim out of the Medical Practice Act. **Ms. Ellis** asked the Committee to approve **H 181** and send it to the floor with a do pass.

Senator Tippetts declared a Senate Rule 39(H) conflict of interest; his son is associated with the same firm as Ms. Ellis.

Senator Tippetts asked her to clarify how those currently practicing and licensed are treated under this legislation. **Ms. Ellis** responded by stating this legislation added a formulary and that is different from Chapter 51; if a naturopathic physician is prescribing outside the formulary in this act, it is a violation. If prescribing under Chapter 51, it is not in violation of this act.

Senator Tippetts asked if it was correct that the term "naturopathic physician" means someone practicing with a license obtained under the provisions of Chapter 51; this language is not included in the definition of "naturopathic physicians" in this act. **Ms. Ellis** stated that as referenced in other sections of **H 181**, they are allowed to call themselves, naturopathic physicians and engage in naturopathic medicine as will be defined by rule in this chapter.

Senator Tippetts stated that in Section 56-5413 "certain acts prohibited", Subsection 3 refers to the practice of naturopathic medicine and Subsection 4 relates to the title. This act does not specify one can practice under Chapter 51, only that one can carry the "naturopathic medicine" title. **Ms. Ellis** stated that when the formulary is added along with minor office procedures, the board will determine the practice of naturopathic medicine under this chapter. This was written to clarify that one must be licensed under this chapter to get that formulary.

Senator Tippetts asked about the penalty provisions that have been written to read that it is a misdemeanor to violate any provisions of Chapter 51 or other rules that are promulgated. The Committee is being asked to pass an act that penalizes any violation of the rules, however the rules have not yet been produced. **Senator Tippetts** asked for an explanation of why there was such a broad penalty provision. **Ms. Ellis** stated most language in this act was negotiated with the Idaho Medical Association and their attorney, and mirrors the Medical Practice Act. Regarding the timing of this act, those provisions will not go into effect for one year, until rules are promulgated and passed by this Committee.

Senator Nuxoll asked why it was necessary to have a doctor on this board if it is for naturopathic physicians. **Ms. Ellis** said in Chapter 51 there was a formulary council set up that was comprised of medical doctors, pharmacists, and naturopathic physicians. The Bureau of Occupational Licenses (Bureau) advised bringing this all under the board. During this time they attended several meetings with the State Board of Medicine and the State Board of Pharmacy; at these meetings there were several individuals who expressed their desire to serve on the board. It is believed the creation of this board will be advantageous in developing a formulary as well as a cost savings benefit.

Senator Nuxoll asked about disclosure of those providing natural healthcare services; why is this section necessary? **Ms. Ellis** explained this language is directly out of the Medical Practice Act as well as Chapter 51. This is not new language, this is for those practicing naturopathic medicine as defined by the Idaho Supreme Court decision; these are legal requirements that currently exist.

Chairman Heider asked that Ms. Ellis explain why the date September 1, 1991 was chosen. **Ms. Ellis** said that is the date used by all other states which license naturopathic medical doctors.

Senator Nuxoll asked how many will get licensed under this new act, and how many would this exclude that are currently practicing or are considered naturopathic physicians. **Ms. Ellis** said approximately 20 licenses will be issued. Idaho is surrounded by states that have a significantly higher amount of licensed naturopathic physicians; the goal would be to bring more doctors to Idaho, not less.

Senator Hagedorn asked about the amendment Ms. Ellis spoke of earlier and if her reason for discouraging an amendment was because it was not possible to define the medical training of those currently practicing; or because the 1991 language was not included in the amendment. **Ms. Ellis** explained that the board tried to do this in the 2005 legislation because Chapter 51 does not have any education standards. The board brought several rules to the Committee; these rules were not approved. There were lawsuits filed initially, with one subsequent lawsuit that was brought about by those who did not obtain a license. The suit was filed against members of the board, State, and Bureau because there had not been a signed agreement with the Board of Occupational Licenses. Ultimately this suit was dismissed; however, it left debt owed by the board. Additionally, this amendment would allow anyone to be on the board, such as chiropractors, who would be establishing the formulary and this was not in the best interest of the public.

Senator Hagedorn asked about the 20 new licenses to be issued and what restricts them from being licensed under Chapter 51. **Ms. Ellis** said that the board is no longer functioning and there are no licenses given out. As a result of the lawsuit, members resigned from the board; there are still two members, but they have not appointed new members for many years. The statute states board appointments must be licensed.

Senator Lodge clarified that at this time there are only two remaining members of the board under Chapter 51. **Ms. Ellis** responded yes, that is correct. **Senator Lodge** asked if the board has any funds or is there only debt. **Ms. Ellis** responded that there is currently debt of approximately \$20,000. **Senator Lodge** asked if the debt was due to the lawsuit filed against the board. **Ms. Ellis** explained it was partially due to the lawsuit; additionally, the rules that were brought were very costly.

Senator Lodge asked for clarification on the difference between a physician and a doctor. **Ms. Ellis** said under this legislation one can call themselves either, it is not restricted. The purpose of this was to avoid interference with Chapter 51.

Senator Heider asked why everyone is allowed to re-license under Title 56 of Idaho Code versus having two different licensing organizations. **Ms. Ellis** said that would be a good question for the Committee; what should the standards be to allow a physician to prescribe medication to someone? Should the physician have been educated at an accredited school, attended clinical, experienced hospital rotation, and worked with other medical doctors? Without this, the public can be treated by non-licensed practitioners such as massage therapists. Should the board decide this is allowable, this can be done under Chapter 51.

Senator Tippetts asked for clarification on the intent of this bill. His understanding is it is not intended to prohibit anyone currently practicing under provisions of the Smith decision or under provisions of Chapter 51. **Ms. Ellis** said that is correct.

Senator Nuxoll asked about exclusion of current practitioners, in regards to naturopathic physicians from other countries that are now practicing in the U.S., and where in this bill is there a grandfather clause. **Ms. Ellis** stated those individuals licensed under Chapter 51 would remain so. This bill not does affect the physicians or their practices. **Ms. Ellis** explained this bill is intended to expand privileges by allowing naturopathic physicians to prescribe legally.

Senator Nuxoll asked about having two sets of rules on the books, each setting a board; how does this work? **Ms. Ellis** stated elderly care has two boards, similar rules for administrators and disciplinary action. The Attorney General stated there was not a constitutional conflict nor were there issues with how it sets up both structurally and legally.

Senator Lodge asked if Ms. Ellis knew if any individuals planned to testify about the different path this new chapter will cover, similar to some explanation of the path taken under Chapter 51. **Ms. Ellis** responded, stating there will be several individuals testifying about this chapter. It has not been defined in Chapter 51, and there will likely be testimony from individuals that will speak on the different avenues of education.

TESTIMONY: Testimony in support of H 181

Dr. Joan Haynes, Naturopathic Physician, IDAANP, discussed the current limitations when a patient needs prescriptions and lab work. Licensing helps insurance companies determine coverage, which in turn helps patients. She explained that under Chapter 51, the board was not functioning correctly; licenses were not required to be renewed nor did they have an expiration date.

Dr. Sara Rodgers, Naturopathic Physician, IDAANP, stated there are many misconceptions and concerns surrounding **H 181** that she would like to address:

- **H 181** will repeal Chapter 51. This is not true, it will not in any way.
- **H 181** will cause a monopoly. This is not correct, the Smith legislation addressed this.
- **H 181** will prevent providers from providing certain services. This is a misconception.

Todd Schlapfer, IDAANP, testified in support of **H 181** stating that lack of licensure prevents naturopathic physicians from doing everything they are capable of doing. Additional concerns were cost and out-of-state collaboration. Passing **H 181** would establish a formulary, and a functioning board would govern licensed naturopathic physicians.

Valerie Dickerson, representing herself, testified in support of **H 181** because the lack of insurance and a clear professional definition have made pursuit of her desired type and level of primary care difficult.

Sharon Van Tyul, RN, stated she supported **H 181** because doctors who graduated from an accredited school and had already passed the national licensing exam would be eligible for licensing in Idaho. She expressed support for education, accredited institutions, exams, hospital rotation and exposure, as proposed by **H 181**.

Testimony in opposition of H 181:

Dr. Jason West, Physician and Owner, West Clinic, opposes **H 181** and discussed how it would affect his profession as a naturopathic physician. His clinic employs ten doctors to meet the medical needs of his patients. He opposes **H 181** because of the prescriptive process and legend drugs; this act brings more administrative responsibility to the physician and limits provider services.

Senator Lee asked about Mr. West's prescriptive process and if he sees a difference between a formulary and permitted services versus other recommendations that providers give to their patients. **Dr. West** replied yes, this is important to his practice because the prescriptive limitations of **H 181** would no longer allow this due to changes in the definitions. Out-of-pocket costs will increase, and he will not be able to compete. This will make for an unfair advantage to those with licensure versus those without.

Senator Lee asked why Dr. West needed a license to practice. **Dr. West** replied the reason for needing a license is to have access to the tools needed to practice naturopathic medicine.

Senator Nuxoll asked where the problem is within the bill, and where is the definition that causes concern. **Dr. West** replied it is in the requirements for licensure.

Senator Hagedorn asked how this bill will affect him if he is a licensed chiropractor under Chapter 51 and has gone through the currently required prescriptive training. **Dr. West** explained this will affect his ability to compete in this industry; he will not be able to provide services in private practice. **Dr. West** referenced legislation and rules that he was told will be written and will be presented that will affect him as well.

Senator Lodge asked how will he be discriminated against if he currently has a staff that includes other medical licensures. Why would he need to have his own private practice? **Dr. West** stated that because of cost, it may become necessary to better serve the patients, and **H 181** will not allow him to be recognized independently.

Garry Shohet, Naturopathic Medicine Physician, representing the Idaho Naturopathic Medicine Physicians, expressed his concern with the limited grandfathering along with eligibility based on fraternity, not competency. The one school identified for grandfathering has historical accreditation issues. He suggested several changes to the legislation that would make it more acceptable.

Dr. Michael Karlfeldt, The Karlfeldt Center, sees challenges with **H 181** because it takes away from traditional naturopathic medicine intent. Isolating the ability to practice to only those with certifications or that have taken the national exam is not how naturopathic medicine originated, nor how it was meant to be practiced.

Jed Adamson, representing himself, explained that naturopathic physicians unable to obtain licensing under Chapter 51 would not be able to do so under **H 181**. Chapter 51 issued a very limited amount of licenses, only 15 were issued, and many naturopathic physicians were unable to obtain a license even after having met all requirements for licensure. There would be less opposition to **H 181** if there was a functional board created and existing under Chapter 51.

Dean Funk, formerly a member of the Idaho State Senate in 1959 and one of the original board members for naturopathic medicine, stated that he has personally used naturopathic medicine for over 40 years. The board was unable to govern itself and there was conflict that prevented it from functioning as it should.

Chairman Heider asked if he believed that it would be possible to re-establish the original board. **Mr. Funk** stated this was not a probability. When it was created there was too much opposition, conflict among the members and a lack of proper process. There was not a formulary that could be agreed upon; therefore, it did not provide consistency for licensure of naturopathic physicians. The board did not establish licensing regulations such as renewal or expirations of the licenses issued.

Senator Hagedorn asked about public safety concerns. **Mr. Funk** replied there were not any public safety issues that he was aware of. **Senator Hagedorn** asked if he knew if anyone monitors or checks on the original licenses. **Mr. Funk** stated it would be addressed in the media if there was an issue, and he believes those with licensure monitor their own people, but otherwise he was not aware of a monitoring system in place.

Jenny Alderete, patient of Dr. Schmillen, testified in opposition to **H 181** because it would exclude her practitioner who received his education in Sweden. There are multiple forms of naturopathic medicine, and she does not want providers to be limited in the type of service they can provide. Her provider saved her life; she wants a bill that supports all forms of practice and the freedom to choose.

Senator Lee stated that even distinguishing between licensed, structured versus non-licensed, non-structured, she believed there would still be the freedom to choose. **Ms. Alderete** responded that her understanding of **H 181** was that the education requirement would affect this.

Dr. Tilden H. Sokoloff, MD, DPM, NMD, explained there has been issues with naturopathic medicine licensure for years. There is conflict and differences of opinion that haven't allowed a good group of providers to be recognized without following a specific educational format and formulary for licensure. Other concerns were the strict guidelines in **H 181** for education by accredited schools in the U.S. and Canada. It affects those who received their education in other countries and have practiced for many years. It also affects those who attended accredited institutions that have closed or no longer offer the programs.

Dr. Scott Nelson, licensed Chiropractor, stated naturopathic physicians who were unable to obtain licensing under Chapter 51 would not be able to do so under **H 181**.

Fred Birnbaum, Idaho Freedom Foundation, opposes this legislation because the actual problem is that it only benefits graduates of five schools and third party payment from insurance. Existing naturopathic physicians would suffer from drastic changes in their current practice, services and quality of care.

Ms. Thompson, patient of Dr. Jason West and the West Clinic, testified that **H 181** would eliminate her existing naturopathic physician from being able to practice or provide services that are necessary to her individual recovery. The ability to choose this type of medical service would no longer be optional, nor allow patients the freedom to choose providers that offer better solutions and better results. Naturopathic physicians provide natural medicine and cures for patients that have been unsuccessful finding help with traditional licensed doctors or prescribed medications. Patients need a choice of providers and reduced cost of care.

Ms. Ellis concluded her presentation by giving a summary and addressing many of the concerns of those opposing **H 181**. She explained there are and will always be complaints whenever new processes are put into place or considered for implementation. This is unavoidable; however, a working board, such as the one created by **H 181**, would address and resolve these issues effectively. Issues arose with the Chapter 51 board when it moved out from under the Board of Occupational Licenses. **Ms. Ellis** stated issues with the original board arose from standards conflicts, not personality conflicts; additionally, there are multiple licensures that qualify under **H 181**. **Ms. Ellis** reiterated that the board will not go into effect until July 2015, and the bill itself will not go into effect until July 2016.

MOTION: **Senator Nuxoll** made a motion to hold **H 181** in Committee. **Vice Chairman Martin** seconded the motion.

SUBSTITUTE MOTION: **Senator Hagedorn** moved to send **H 181** to the 14th Order for amendment. **Senator Lee** seconded the motion.

ROLL CALL VOTE: **Chairman Heider** called for a roll call vote. **Senators Lodge, Hagedorn, Lee, Schmidt** and **Jordan** voted aye. **Senators Nuxoll, Tippetts, Vice Chairman Martin** and **Chairman Heider** voted nay. The motion passed. **Senator Nuxoll** asked to be recorded as voting nay.

ADJOURNED: There being no further business to come before the committee, **Chairman Heider** adjourned the meeting at 6:04 p.m.

Senator Heider
Chair

Erin Denker
Secretary



Idaho Statutes

TITLE 54 PROFESSIONS, VOCATIONS, AND BUSINESSES

CHAPTER 51 NATUROPATHIC PHYSICIANS LICENSING ACT

54-5108. BOARD OF NATUROPATHIC MEDICAL EXAMINERS. (1) There is hereby established in the department of self-governing agencies, bureau of occupational licenses, the board of naturopathic medical examiners.

(2) The board shall consist of five (5) members, four (4) of whom shall be licensed pursuant to this chapter and one (1) of whom shall be a member of the public with an interest in the rights of consumers of naturopathic physician services.

(3) One (1) member of the initial board shall be appointed for a one (1) year term of office, one (1) member of the initial board shall be appointed for a two (2) year term of office, one (1) member of the initial board shall be appointed for a three (3) year term of office, one (1) member shall be appointed for a four (4) year term of office, and one (1) member of the initial board shall be appointed for a five (5) year term of office. Thereafter, the term of office for each member shall be five (5) years. Members shall serve at the pleasure of the governor.

(4) Appointments to the board shall be made by the governor. Prior to the expiration of the regular term of a member of the board or upon the occurrence of declaration of a vacancy in the membership of the board, the governor shall notify in writing the Idaho association of naturopathic physicians and the Idaho chapter of the American association of naturopathic physicians thereof, and each association shall, within thirty (30) days thereafter, nominate one (1) or more qualified persons to fill such vacancy and shall forthwith forward the nominations to the governor, who shall thereupon appoint from such nominees, the person to be a member of the board to fill such vacancy.

(5) The four (4) members of the board who are naturopathic physicians shall be licensed pursuant to this chapter, practicing within the state of Idaho for the duration of their appointment and shall have been practitioners within the state of Idaho for a minimum of two (2) years immediately preceding appointment.

(6) The initial four (4) licensed naturopathic physician members of the board shall be persons with at least two (2) years of experience in the practice of naturopathic medicine who are eligible to become licensed pursuant to this chapter. In the event of death, resignation or removal of any member before the expiration of the term to which appointed, the vacancy shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(7) The board, within thirty (30) days after its appointment, and at least annually thereafter, shall hold a meeting and elect a chairman. The board may hold additional meetings on the call of the chair or at the written request of any two (2) members of the board. The board may appoint

Attachment 1

such committees as it considers necessary to carry out its duties. A majority of the board shall constitute a quorum.

History:

[54-5108, added 2005, ch. 329, sec. 1, p. 1030; am. 2008, ch. 406, sec. 1, p. 1115.]

15

CHAPTER 56

16

NATUROPATHIC MEDICAL PHYSICIANS LICENSING ACT

17

54-5601. LEGISLATIVE PURPOSE AND INTENT. It is the intent of the Idaho

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legislature to regulate the practice of naturopathic medicine. Nothing in

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this chapter will limit the decision in State v. Smith, 81 Idaho 103, 337

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P.2d 938, except to the extent that certain modalities of treatment shall

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require a license pursuant to this chapter. Furthermore, it is not the in-

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tent of this chapter to prohibit the use of the term "doctor" nor to limit the

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practice of naturopathy as explained in State v. Smith.

28 54-5608. QUALIFICATIONS FOR LICENSURE. To be eligible for a license to
29 practice as a naturopathic physician in the state of Idaho, the applicant
30 shall submit an application, pay the fee and fulfill the following require-
31 ments:

32 (1) Education.

33 (a) The applicant must be a graduate of an approved naturopathic medi-
34 cal program as defined in section 54-5602(1), Idaho Code; or

35 (b) The applicant must be a graduate of a college or university in the
36 United States or Canada, prior to September 1, 1991, that is still in
37 existence and that offered a full-time structured curriculum in basic
38 sciences and supervised patient care comprising a doctoral naturo-
39 pathic medical education as a prerequisite to graduation, having been
40 not less than one hundred thirty-two (132) weeks in duration and that
41 required completion within a period of not less than thirty-five (35)
42 months and have been continually practicing for five (5) years immedi-
43 ately preceding licensure.

44 (2) Examination. Applicants who meet the qualifications of subsection
45 (1) (a) of this section and all applicants after July 1, 2016, shall provide
46 proof of having received a passing grade on the naturopathic physicians li-
47 censing examinations (NPLEX), administered by the North American board of
48 naturopathic examiners (NABNE). The passing grade for each specific exami-
49 nation administration shall be as determined by the NABNE.

Attachment # 4

26 54-5605. NATUROPATHIC PHYSICIAN LICENSE REQUIRED. (1) A license shall
27 be required for a person to engage in the practice of naturopathic medicine.

28 (2) No person shall assume or use the title or designation "doctor" or
29 "physician" in association with the practice of naturopathic medicine, or
30 the abbreviations "NMD" or "ND" or any other title, designations, words,
31 letters, abbreviations, sign, card or device to indicate to the public that
32 such person is licensed to practice naturopathic medicine pursuant to this
33 chapter unless such person is so licensed under this chapter or allowed under
34 section 54-5103, Idaho Code.

35 (3) Nothing in this chapter shall prohibit the use of the term "doctor"
36 or "physician" by a person defined or licensed as such pursuant to title 54,
37 Idaho Code.

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Tuesday, March 17, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for March 3, 2015	Senator Lee
Gubernatorial Appointment Hearing	Mark Von Lindern of Lewiston, Idaho, was appointed to the Hazardous Waste Facility Siting Licensing Application Review Panel for a term commencing March 6, 2016, and expiring March 6, 2018.	Mark Von Lindern

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider	Sen Tippetts
Vice Chairman Martin	Sen Lee
Sen Lodge	Sen Schmidt
Sen Nuxoll	Sen Jordan
Sen Hagedorn	

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Tuesday, March 17, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:00 p.m.

MINUTES APPROVAL: **Senator Lee** moved to approve the Minutes of March 3, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

GUB APPT: **Chairman Heider** introduced Mark Von Lindern as gubernatorial appointee to the Hazardous Waste Facility Siting License Application Review Panel (Panel) for a term commencing March 6, 2015, and expiring on March 6, 2018.

Mark Von Lindern, Senior Manager, Environmental Engineering, Alliant Techsystems (ATK), Lewiston Operations, said he has lived in Idaho most of his life. He graduated from Lewiston High School and the University of Idaho College of Engineering. He was formerly the Public Works Director for the City of Lewiston, then Water Quality Engineer for the Idaho Department of Environmental Quality (DEQ) and subsequently Regional Administrator for DEQ Region 2 in Idaho for 5 years. He has had a good opportunity to work with the DEQ staff and understands the environmental issues throughout the Lewiston district and across the State. In 1990, he went to work for a private company called Blount in Lewiston that grew into ATK which builds everything from .22 ammunition to space shuttle rockets.

Mr. Von Lindern said he has served three 3-year terms on the Panel over the last 25 years. The Panel has not been very active with respect to opportunities, which he said is probably a good thing, but they met a couple of times on expansions at the hazardous waste facility near Grandview approximately eight years ago. He has enjoyed bringing his experience to the Panel with respect to the State's environmental issues. **Mr. Von Lindern** thanked the Committee for the opportunity and stood for questions.

Vice Chairman Martin thanked Mr. Von Lindern for his service and asked him to tell the Committee more about the Panel. **Mr. Von Lindern** said the Panel was formed when there was public interest and discussion about the need for oversight when hazardous waste sites were going to be expanded or brought into the State, particularly at the Idaho National Engineering Laboratory (INEL). The Panel is comprised of people from different academic areas, industries, and the public sector who meet together and go to public hearings to provide testimony.

Senator Schmidt asked if the panel was fully appointed with everyone that is supposed to be on the panel according to Title 39, Chapter 58. **Mr. Von Lindern** said he is acquainted with a few members who have been reappointed, but he cannot speak for the full panel. **Senator Schmidt** said there are requirements of different people from different areas. He asked Mr. Von Lindern if he is a representative of the State or of a private entity. **Mr. Von Lindern** said he is the representative for the large quantity generator industry.

Chairman Heider asked if the Grandview site has had any issues. **Mr. Von Lindern** said yes, in the mid 1980s environmental regulations were not established well enough to be comfortable with the facility. He said as regulations became more defined and people became more astute and knowledgeable about receiving materials at the site and preparing to send them there, he has become very comfortable with the Grandview site. He said it has been managed very well for the last 15 to 20 years.

Senator Nuxoll asked if the Clearwater Basin Advisory Group (BAG) is the same as the Clearwater Basin Collaborative. **Mr. Von Lindern** said no, they are not the same. The Clearwater BAG, which he sits on, is a group that was put together under a DEQ and Environmental Protection Agency agreement for establishing watersheds in the State to determine if beneficial uses were being achieved. A number of different basins in the State have local collaboratives that have more defined information on specific watersheds. The Clearwater BAG acts as the overall umbrella over the collaboratives.

Senator Tippetts thanked Mr. Von Lindern for his service.

Senator Hagedorn also thanked Mr. Von Lindern for his service and asked what has been his biggest environmental challenge in all the years he has been at ATK. **Mr. Von Lindern** replied wastewater issues have been the biggest challenge. He said ATK's facility discharges to the City of Lewiston's wastewater treatment plant under a pretreatment permit, and the City discharges into the Clearwater River. The Clearwater and Snake Rivers have threatened and endangered species in them, so the wastewater discharge requirements are stringent. He said ATK's compliance record has been extremely good, but oversight is costly in terms of money and 24-hour-a-day manpower.

MOTION:

Senator Tippetts moved to send the gubernatorial appointment of Mark Von Lindern to the Hazardous Waste Facility Siting License Application Review Panel to the floor with recommendation that he be confirmed by the Senate. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**. Senator Nuxoll will carry the confirmation on the floor.

ADJOURNED:

There being no further business, **Chairman Heider** adjourned the meeting at 3:21 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Paula Tonkin
Assistant Secretary

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Wednesday, March 18, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for January 30, 2015	Senator Martin
	Approval of the Minutes for February 26, 2015	Senator Martin
Gubernatorial Appointment Consideration	Suzanne Budge of Boise, Idaho, was appointed to the Hazardous Waste Facility Siting License Application Review Panel for a term commencing March 6, 2015, and expiring on March 6, 2018	Suzanne Budge
<u>S 1123</u>	RELATING TO INDIGENT SICK - To define terms and make technical corrections; Revise provisions regarding the powers of duties of the board of the catastrophic health care cost program	Senator Schmidt Kathryn Mooney , Director Catastrophic Healthcare Program Anthony J. Poinelli Deputy Director Idaho Association of Counties

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Wednesday, March 18, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippets, Lee, Schmidt and Jordan

**ABSENT/
EXCUSED:** None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

MINUTES APPROVAL: **Vice Chairman Martin** moved to approve the Minutes of January 30, 2015. **Senator Tippets** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Vice Chairman Martin** moved to approve the Minutes of February 26, 2015. **Senator Tippets** seconded the motion. The motion carried by **voice vote**.

GUBERNATORIAL APPOINTMENT: The appointment of Suzanne Budge of Boise, Idaho, as a member of the Hazardous Waste Facility Siting License Application Review Panel (Panel) for a term commencing March 6, 2015 and expiring on March 6, 2018.

Suzanne Budge stated that she had received her undergraduate and graduate degrees in geology from Utah State University and the Colorado School of Mines respectively. She has returned to Idaho to do environmental work. **Ms. Budge** indicated that she was a geologist working with a review panel put together several years ago. One of their projects was Envirosafe in the Owyhee desert and the other was at the Idaho National Engineering Laboratory (INEEL). The Panel consists of a varied group of people, and she filled one of the spots that would be needed if a project were to become involved with the DEQ.

Senator Schmidt asked if she had any recommendations for making the Panel more effective. **Ms. Budge** indicated that possibly the actual need for the Panel could be evaluated. There are very specific facilities that deal with hazardous waste and not many are in Idaho. **Senator Hagedorn** asked if Ms. Budge had ever been involved in any nuclear waste reviews. **Ms. Budge** stated that one of the proposed projects reviewed by the Panel was INEEL.

MOTION: **Senator Tippets** moved to send the gubernatorial appointment of Suzanne Budge as a member of the Hazardous Waste Facility Siting License Application Review Panel to the floor with the recommendation that she be confirmed by the Senate. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

Relating to Indigent Sick: **Senator Schmidt** indicated that this legislation concerns the "process." Senator Schmidt serves on the Catastrophic Healthcare Fund Board (Board). Applications from the counties that exceed \$11,000 are reviewed by the Board. Applying for indigency begins in the counties and payments are made at the state level. The processes are overseen by the Idaho Association of Counties on the state level, but every county has their own indigent coordinator. The statute specifies what their responsibilities are and what claims ultimately go to the State so they can have a uniform process for making the determination of what is paid. This legislation would change a part of the process that the payers and providers are hoping to clarify.

Senator Tippetts asked if Senator Schmidt was aware of any opposition to the legislation. **Senator Schmidt** replied that the Idaho Hospital Association (IHA) indicated they had not had time to get responses from all of their members. The CAT Board ultimately decides whether to make payments on the claims. This legislation would help to resolve the conflicts between the IHA and the CAT Board regarding who should be paid and how much the payment should be. **Senator Schmidt** stated that there has been significant interest in making sure that this legislation is fully vetted. Part of the reason this legislation is late in the session is because of the time requested by IHA.

TESTIMONY:

Kathryn Mooney, program director, Catastrophic Healthcare Program, began by stating that attorneys from the IHA and one of the providers were included in drafting this legislation. The focus is to streamline the program and provide consistency statewide. **Ms. Mooney** gave a history of the progression of the county payment procedures and how they eventually end up with the CAT Fund. She stated that there are about two and a half people who are basically responsible to pay the bills and go through whatever legal proceedings occur. This is a payer program, and streamlining it will ultimately save the State money. Work began on this legislation in October and there were communications with the IHA relating to their concerns during the ensuing months. This legislation would enable everyone to use the same paperwork and keep operating procedures consistent throughout the State (see attachment 1).

Chairman Heider asked if this would make the process easier and more accurate. **Ms. Mooney** responded that she thought it would. One of the main benefits would be that much of what is currently being determined in the courts would be taken care of without going through that system. Much input was given so that the language was clear, concise and made sense to all parties involved. Patients are guided through the process by either the hospital or the county. Emergency applications come from providers. They are given to Health and Welfare first for a Medicaid determination. If they do not qualify, they go to the counties. This is a combined application. Non-emergent applications can be filed at the county level, and patients or hospitals can file that paperwork.

Senator Tippetts referred to page 14 where it reads "any medical claims that are not submitted within the time frame . . . shall not be paid nor shall it be considered a debt of the applicant." He asked if that was still current practice. **Ms. Mooney** stated that the standard is that patients won't be taken to collections. The bill paying process is very long and payment is not always timely. Also, payment is not the full billed price. Payment is based on the Medicaid rate, their own reimbursement rate definition, plus a 5 percent discount. Anything that isn't paid does not become the responsibility of the patient. The statement clarifies that it applies to all bills that have to do with a particular procedure.

Senator Nuxoll asked what it means to "administer alternative care options." **Ms. Mooney** stated that the original writing of this legislation did not include the use of skilled facilities. The definition now includes rehab and some full scale interim residential facilities. That level of care is more beneficial to patients and saves the taxpayer money. **Senator Nuxoll** asked if this referred just to process as far as applying for CAT Fund aid and would not add more cost or increase in payments. **Ms. Mooney** responded there is one provision on page 16, line 48, in S 1158 from 2009 that was taken out. The commissioners who are members of the Board are the only ones who have any travel reimbursement to attend meetings. There is an operating expense of about \$7,000. Most meeting participation is done remotely, but occasionally they do travel to attend meetings. It is costly for the commissioners to do all of the travel required. Bonneville County pays for all of the chairman's travel. At some point a chairman from a smaller county may be appointed, and his county may not be able to pay for his costs. A participant from a smaller county may decline to be chairman because of these costs. The amount would still not exceed \$7,200. Operating expenses of about \$400,000 a year are paid out of the Catastrophic Healthcare Fund. This would increase that amount by about \$7,000.

Senator Lee referenced page 4, section B, line 25, and asked if that language had been used elsewhere or if it was just being clarified. **Ms. Mooney** stated that it was almost verbatim to the one above it. That one had been added to cover weight loss procedures at the suggestion of two doctors on the CAT Board. If unnecessary medical procedures are performed and complications arise, the ongoing payment of costs for those would not be necessary.

Chairman Heider thanked Ms. Mooney for her testimony.

Senator Schmidt thanked the Committee for hearing this legislation. He summarized by saying that the main thing this legislation is trying to do is combine the application process into one standard application rather than two different ones.

Chairman Heider asked if the hospital ultimately determines the cost of the care that is passed on to the Board. **Senator Schmidt** explained how the amount of the bill is arrived at. **Chairman Heider** asked if there was a checks and balance system. **Senator Schmidt** said that there is a medical review system so that when a bill is above a certain amount, it is reviewed to determine whether or what portion will be paid. He indicated there was some negotiation in this process.

Senator Nuxoll asked whether the commissioners made a determination in payment of costs. **Senator Schmidt** said that it was done at the county level. The CAT Board receives the applications from the counties that are greater than \$11,000. It is not up to the Board's determination whether the patients are able to pay their medical bills within five years. That determination goes back to the counties. **Senator Schmidt** asked the Committee to send **S 1123** to the floor with a **do pass**.

MOTION:

Senator Lodge moved to send **S 1123** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**.

ADJOURNED:

There being no further business, **Chairman Heider** adjourned the meeting at 3:42 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Sharon Pennington
Assistant Secretary

Legislative bullets

Many of these things are just to codify current practices and to create consistency state wide. This is in collaboration with some local providers.

DEFINITIONS 31-3502

- (1) Clarifies that an applicant can also be an obligated person who is assisting the patient in this process. P.1
- (7) Clarify -a combined application is for applying to the DHW and the counties for assistance. An application is 'good for' 6 months. This is practice, but all felt should be defined as well. P.2 line 14
- (8) Clarify definition of completed application. There have been 2 district court decisions involving the discussion of what constitutes a 'completed' application. We believe this clarifies what the courts have stated. (8) p.2 line 22

Clarifies definition of Necessary Medical services

- (19) (A) Attempting to bring 'skilled nursing' term into the 21st century. Original intent was to avoid burdening taxpayer with long term care costs. This will separate out limited nursing care as a lesser cost setting for treatment. (19) A&B p.4 line 6
- (19)(B) to state that services created by complications which arise from those procedures or treatment that are not covered by our statute, are also not covered by statute.... P.4 Line 26
- (25) Modifies residency definition as it relates to college students and who is considered a county resident. To align with new SHIP code. P5 line 2
- (29) Creates a NEW definition of something that's been used for years...a treatment plan- an attempt at consistency so the providers know what will be accepted at every county statewide. (29) p.5 line 37

Codifies the practice in place between counties and the state when reporting to the state legislature. 3503(A) P.6 line 24

Clarifies that states where we have reciprocal agreements must comply with Idaho law (and the application process) if they want coverage for Idaho Residents. (Only Oregon and Utah still have reciprocal agreements with Idaho) 3503(B) P.7 line 13

3504 strikes antiquated language, made obsolete in 2010 by SB1158 P7 line 29-33

3504 (3) strikes section from line 1-10 and moves it to 3505 (3)

3504 (4) Clean up and broaden the process for medical records requests to specify 14 **calendar** days allowed instead of 10 days to soften the blow and allow that only related **claims** may be denied instead of the entire application for non compliance, And to stress that during this time a county can continue to investigate and interview person. Electronic age updating: Allow for several things to be sent electronically, to allow the counties and the providers to create a process for electronic communication between the interested parties. P8 line 34 and p.9 line 1-12 and in 3505(C).

3505 et seq. to codify practice in the area of filing applications for assistance. Clarifying we use 'calendar' days in all we process. Codifying the specifics of how 10 day applications for pre authorization of procedures and treatment are filed.

Specifying how additional requests can now also be used including with emergent apps.

3505 cont. (8) Clean up: labeling of all applications as 'combined' not just 'county' applications Changed to combined in S1158 Session 2009

3505(A) lengthens timelines for a more reasonable process...A segue off of the lengthening of the medical records response time for providers from 10 to to 14 days – in 3504. Page 11 (3) line 36

3505(C) Strengthens provision to require counties to provide info to 3rd party applicants, including list of missing items to give the providers a reasonable chance to investigate in tandem with the county. P. 12 Line 5...on

3505(D) Requires details on a request for appeal, to help determine the hearing agenda. P 13 Line 13

3508(A) Clarifies that all claims relating to an application are pursuant to the provisions of this chapter and can not be held out as a separate debt to the patient if the provider fails to comply with statute during the process. P 14 line 33

3508(A) continued...page 15. The county is required to provide specific documents to the CAT Fund for payment processing. This codifies the list. Lines 1-9

3511 To clarify compliance between the counties and CAT Board. P. 15 Line 46 to P16 line 2

3517 (4)(e) To reinstate travel expense reimbursement for commissioners who sit on the CAT Board. To cover 2 meetings a year. When the intent in session 2010 was to move the program into more oversight by the leg and the dept. this was taken out. That hasn't happened and we'd like it reinstated.

Changes the word *decisions* to determinations throughout the chapter– a more definitive description of the county commissioners written findings.

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
3:00 P.M.
Room WW54
Thursday, March 19, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Minutes Approval	Approval of the Minutes for February 25, 2015	Senator Hagedorn
<u>S 1153</u>	RELATING TO INDIGENT SICK - To revise the declaration of policy relating to who is eligible for the County Medical Indigent Program and Catastrophic Health Care Cost Program	Senator Hagedorn Rep. Janet Trujillo
Presentation	Idaho Counseling Association Presentation	Susan Perkins PhD, LAMFT, LPC Dennis Baughman

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider	Sen Tippetts
Vice Chairman Martin	Sen Lee
Sen Lodge	Sen Schmidt
Sen Nuxoll	Sen Jordan
Sen Hagedorn	

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, March 19, 2015

TIME: 3:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Hagedorn, Tippetts, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: Senator Nuxoll

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 3:03 p.m.

MINUTES APPROVAL: **Senator Hagedorn** moved to approve the Minutes of February 25, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

S 1153 **Senator Hagedorn** stated that the bill would limit anyone above 138 percent of the poverty level to eligible for the State's Catastrophic Health Care Cost Program (CAT) and the County Medical Indigent Fund. The eligibility for these funds will be determined by the State and the county.

Vice Chairman Martin questioned how will individuals know they are no longer covered. **Senator Hagedorn** answered the hospitals will help people fill out the forms and the forms are sent to the county, then the county determines whether they are eligible. **Vice Chairman Martin** queried as to the coverage now and what happens when the bill passes and people are no longer covered. Who would pay the bill? **Senator Hagedorn** said no one is covered through the CAT Fund. The fund is for those who have medical bills and submit them to the indigent fund for help in paying them. The county board reviews to see if they should be paid through the CAT Fund. Those that are 139 percent and above qualify and should have insurance through the Affordable Care Act (ACA).

Vice Chairman Martin questioned if they don't have insurance and are not covered by the indigent fund, then are they responsible for the bill. **Senator Hagedorn** replied that is correct. They made the choice not to get insurance even though it is a federal law.

Vice Chairman Martin asked who pays the bill if the people do not. **Senator Hagedorn** explained the people would have to negotiate independently with whomever they owe the money to.

Senator Lee questioned how a hospital would go about collecting money owed by those not insured and not covered by the CAT Fund. **Senator Hagedorn** said those who are above 138 percent are federally required to be insured, and not getting insured is a personal choice. If that is the choice, then they must negotiate with whomever they owe the money to.

TESTIMONY:

Toni Lawson, Vice President of the Idaho Hospital Association (IHA), stated the community hospitals provide much of the services for those Idahoans impacted by this legislation and would ask for a no vote on this bill. This bill simply shifts cost from the State and counties to the private sector. IHA uses valuable resources to enroll people in various types of coverage. There is no educational opportunity to learn about the bill's mandate. Idaho has many people who are medically indigent for various reasons.

Ms. Lawson explained that the cost will shift to hospitals, doctors and ultimately the public. Most patients impacted by this bill will not even know about it until it is too late, and then they are faced with medical bills they cannot afford. It provides savings for some and puts the cost on others.

Ms. Lawson stated Idaho hospitals are already being forced to absorb almost \$700 million dollars in cuts over the next 10 years due to sequestration, regulatory changes and other federal legislative cuts. Some of these costs were to offset coverage through Medicaid. These cuts are difficult for small rural hospitals to absorb particularly if the hospitals provide additional options for coverage for Idahoans who cannot afford it. Now hospitals will be expected to cover those cuts along with the costs of this policy change.

Senator Lee questioned what of the hospitals would do if they needed to recoup costs by those who are above the 138 percent and do not have insurance. **Ms. Lawson** replied they look elsewhere for coverage for these people. It is better to be covered than to be paying on an episodic basis. If there is no qualification for other coverage, then the paperwork is filled out for the CAT Fund. If there is no money, the hospitals absorb the cost through charity care options or bad debt.

Senator Schmidt questioned the size of the population that is above the 138 percent level and that will not get insurance; is it changing? **Ms. Lawson** replied she does not know the numbers and yes, it is changing.

Senator Hagedorn asked for clarification on the hospital absorbing the cost of unpaid bills. Is there a debt collection program used to get funds back? **Ms. Lawson** replied it is a varied approach. For a family of four making a little over the poverty line it is hard to pay large medical bills. Hospitals work with patients to come up with to a payment plan, if possible.

Senator Hagedorn questioned if the debt is built into the following years budget.

Ms. Lawson answered yes, it goes into the budget to be absorbed.

Senator Lodge asked if the costs shift to those who can pay the bills so that the bills become higher for those who do pay. **Ms. Lawson** answered yes, there is a cost shift. The more non-reimbursed care a hospital provides the more those costs end up as a charge to those who can pay. **Senator Lodge** asked if there was a difference between for-profit versus non-profit hospitals and how it would affect their budgets. **Ms. Lawson** answered in most cases the answer is no, there is no difference. All hospitals are mandated to provide care. **Senator Lodge** asked for the bad debt numbers. **Ms. Lawson** replied it was 111.8 million for fiscal year 2012, the last year there is data for.

Senator Hagedorn thanked Ms. Lawson for her help and comments. **Senator Hagedorn** spoke to the bad debt being a number before the ACA began. No-one knows the bad debt numbers for today since people are supposed to be carrying insurance. This bill is good policy for the State and hospitals; although they believe they will absorb 7.5 million, in reality the customers will be absorbing the costs along with the insurance companies. Those who are above the 138 percent level are required by law to have insurance.

MOTION:

Senator Schmidt moved to send **S 1153** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion.

Senator Jordan questioned the expansion of Medicaid or if it had it been accommodated and used would it have given more relief to the families? **Senator Hagedorn** replied the expansion of Medicaid was an option discussed earlier and it was not part of the exchange bill, so it was never taken up. He believes it would have covered those under the 138 percent level.

Senator Tippetts stated he has seen first hand charity care and bad debt and what they do to a hospital. The ACA has a negative impact on hospitals in that the Medicaid reimbursement has been reduced by two percent. It is another additional cost that hospitals have had to absorb. Small rural hospitals are struggling.

Senator Lodge mentioned the state does not have all the statistics the ACA began, and Committee needs to wait and look at those.

Senator Lee stated this change will be significant for the hospitals in her district. As the State has looked at better health care solutions, Idaho has always pushed for personal responsibility.

Senator Martin explained he was excited about the State exchange and that the CAT fund in Bonneville has had significant drops in its usage. There is a shift with this bill of the payment to the individuals and others, but wonders if that is where it needs to be.

Senator Schmidt said there are some costs that are not being talked about. As part of the ACA, hospitals are going to be experiencing significant cuts. This bill is a message to those who need to get their personal insurance. Idahoans are enrolling in the exchange, and by and large people are getting insurance. This bill is a statement that the State is not going to be covering you if you chose not to get insurance when you should have.

Chairman Heider commented it is a federal requirement to get insurance. If you do not, it is not the hospital's fault. The bill places emphasis on getting insurance, but it does not provide a solution.

**ROLL CALL
VOTE:**

Chairman Heider called for a roll call vote. **Senators Schmidt, Hagedorn, and Lee** voted aye. **Vice Chairman Martin, Senators Lodge, Tippetts, Jordan, and Chairman Heider** voted nay. Senator Nuxoll was absent. The motion failed.

PRESENTATION: **Susan Perkins**, Idaho Counseling Association (ICA), spoke on the mental health statistics of Idaho and how counselors believe they can help fill needs and improve Idaho's mental health areas. Counselors want to be part of the solution. **Ms. Perkins** explained what counseling is and what counselors do, training of counselors and Idaho's ranking in mental health topics (see attachment 1).

Chairman Heider questioned the placement of Idaho as 51st in providing mental health care. **Dennis Baughman**, Idaho Project Director at Lifeways, said when a determination is made it takes in Puerto Rico, the DC area and U.S. territories.

Senator Tippetts asked for clarification that Idaho could be 51st in a variety of mental health services offered. **Ms. Lawson** stated that different research data has varying factors, and this particular statistic is for mental health funding per capita.

Senator Schmidt stated the number is incorrect. He had researched the number and would visit with Ms. Perkins to clarify the information.

Mr. Baughman discussed code of ethics, along with the Telehealth and the future for counseling in Idaho (see attachment 1).

ADJOURNED:

Chairman Heider thanked Ms. Perkins and Mr. Baughman for their presentation. There being no further business, **Chairman Heider** adjourned the meeting at 3:53 p.m.

Senator Heider
Chairman

Erin Denker
Committee Secretary

Barbara Lewis
Assistant Secretary

Comparable Training for Licensed Mental Health Professionals

Medicare covers mental health services provided by psychiatrists, psychologists, mental health clinical nurse specialists and clinical social workers. Licensed Professional Counselors (LPCs) and Marriage and Family Therapists (MFTs) are not covered, despite the fact that both groups have education, training and practice rights equivalent to or greater than existing covered providers. Both LPCs and MFTs are licensed for independent practice in all 50 states, and are covered by private sector health plans.

	Licensed Professional Counselor (LPC)	Licensed Clinical Professional Counselor (LCPC)	Licensed Associate Marriage & Family Therapist (LAMFT)	Licensed Marriage & Family Therapist (LMFT)	Licensed Social Worker (LSW)	Licensed Master Social Worker (LMSW)	Licensed Clinical Social Worker (LCSW)
Education	Master's or doctoral degree in mental health counseling or a related field (min 60 credits)	Master's or doctoral degree in mental health counseling or a related field (min 60 credits)	Master's or doctoral degree which qualifies for licensure as a marriage and family therapist (min 60 credits)	Master's or doctoral degree which qualifies for licensure as a marriage and family therapist (min 60 credits)	Bachelor's degree	Master's or doctoral degree in social work	Master's or doctoral degree in social work
Experience	1,000 hours supervised experience in a graduate program	2,000 hours of post-graduate supervised practice (3,000 hours total)	1,000 hours supervised experience in a graduate program	3,000 hours total supervised experience in mft	None for licensure	None for licensure	3,000 hours of post-graduate supervised clinical practice
Licensure Required	Yes	Yes	Yes	Yes	Yes	Yes	Yes
National	~120,000		~55,000		~200,000		
Idaho	1162	887	14	269	1,813	1,326	1,266
Medicare Reimbursement	No	No	No	No	Yes	Yes	Yes

*Title of licensure varies by state



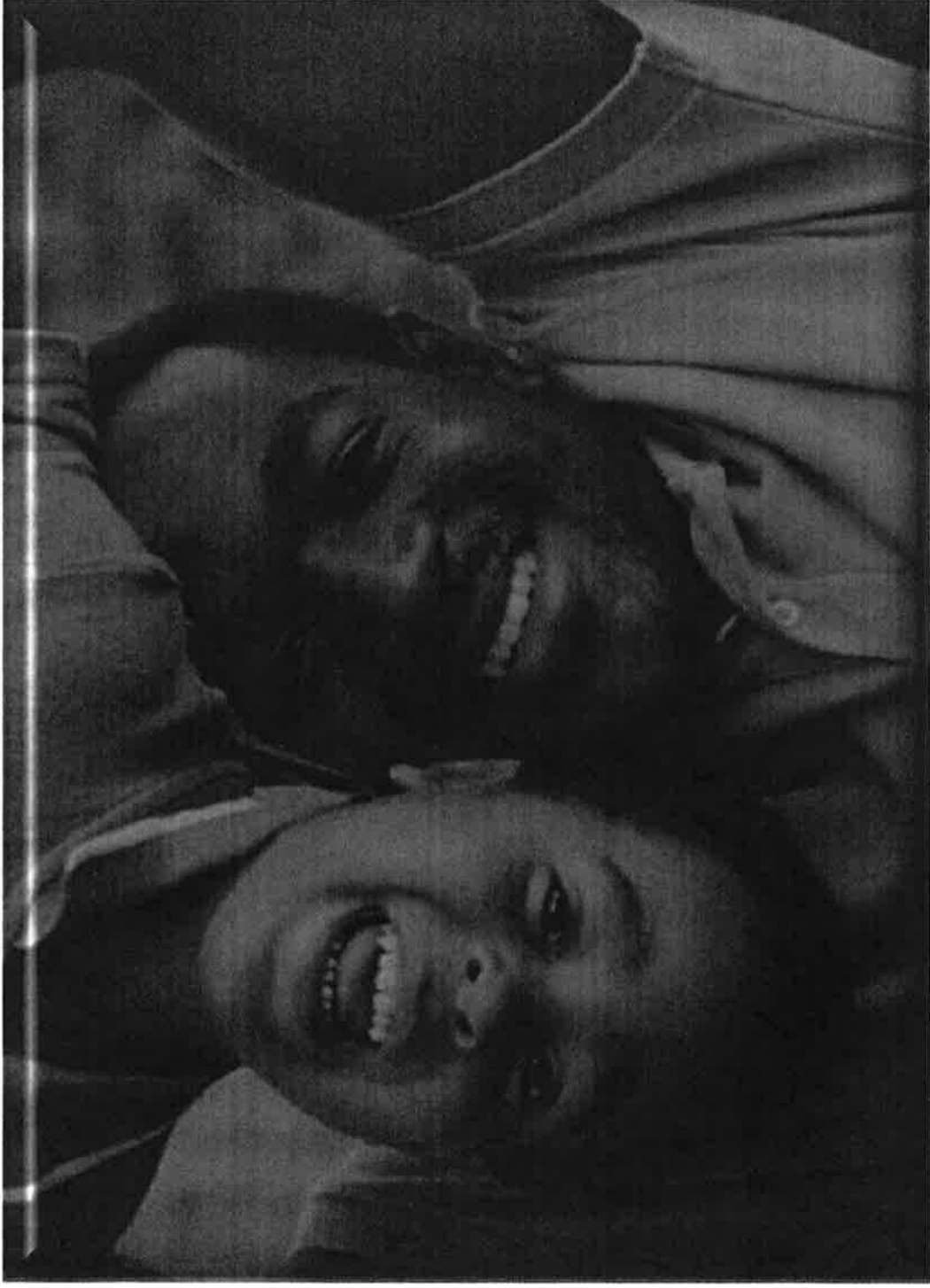
Susan N. Perkins, PhD, LAMFT, LPC ICA President
Dennis Baughman, MA, LCPC ICA PP&L Committee

www.idahocounseling.org

What is Counseling?

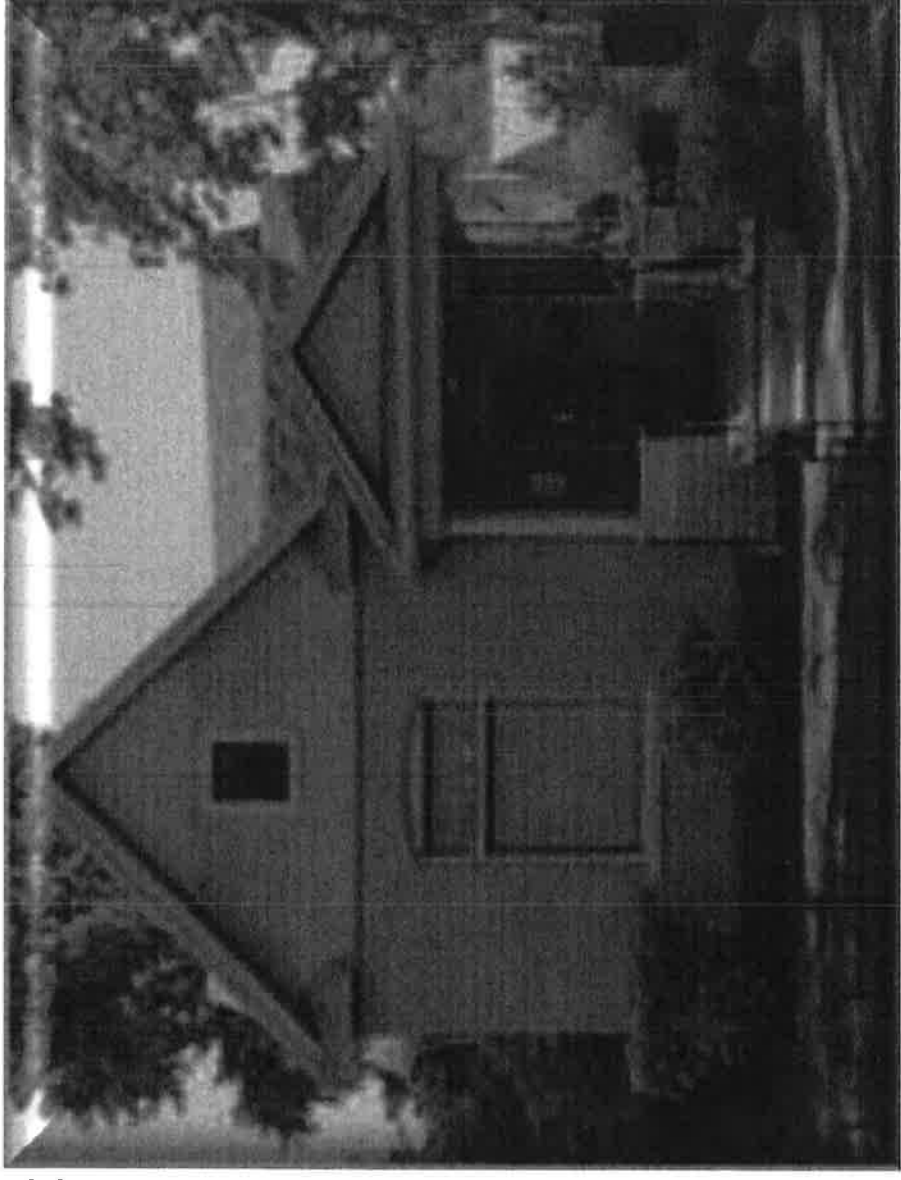


What Do Counselors Do?



Where Do Counselors Work?

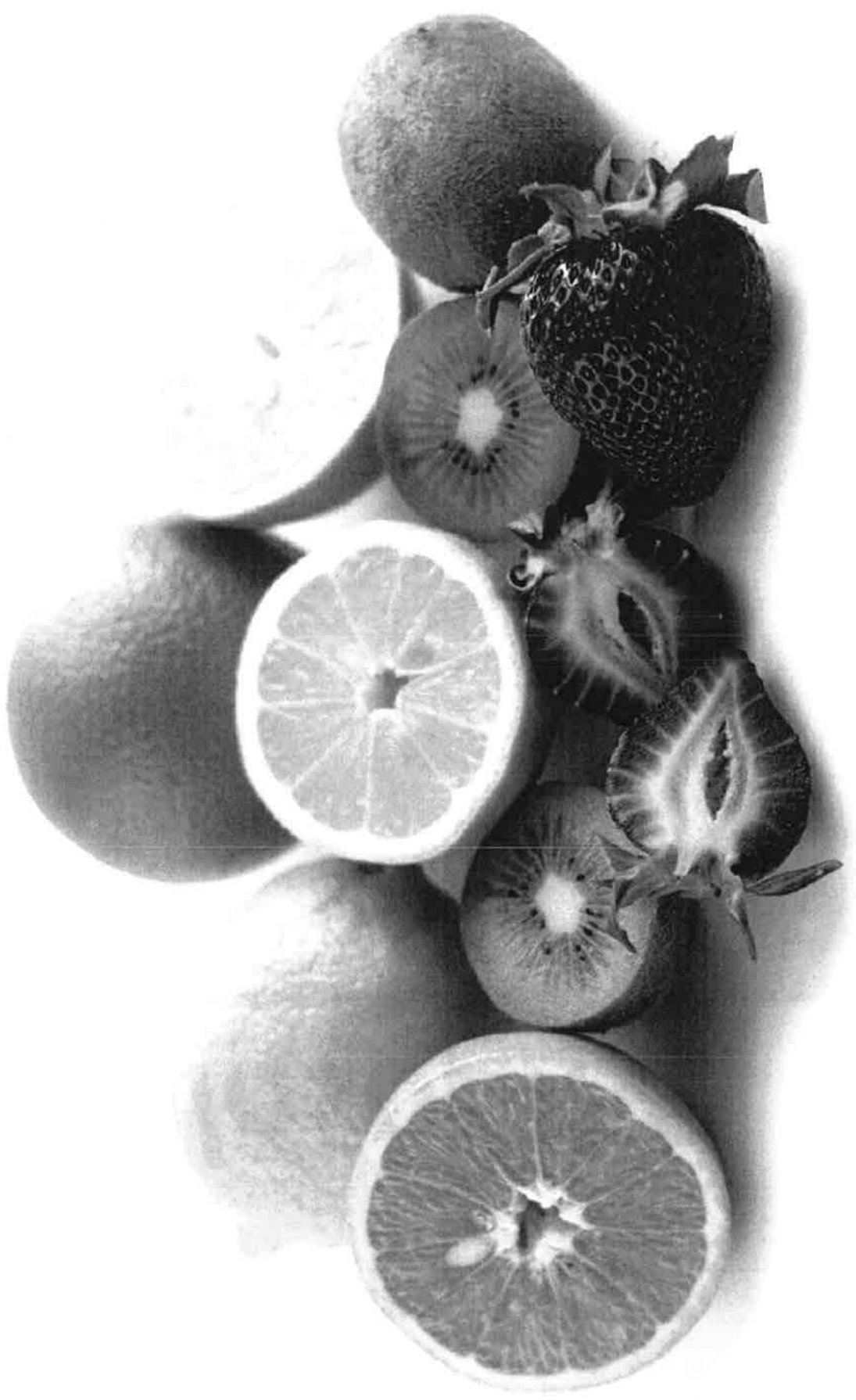
- Schools and Universities
- Government
- Business
- Health Care
- Residential
- Agencies
- Private Practice



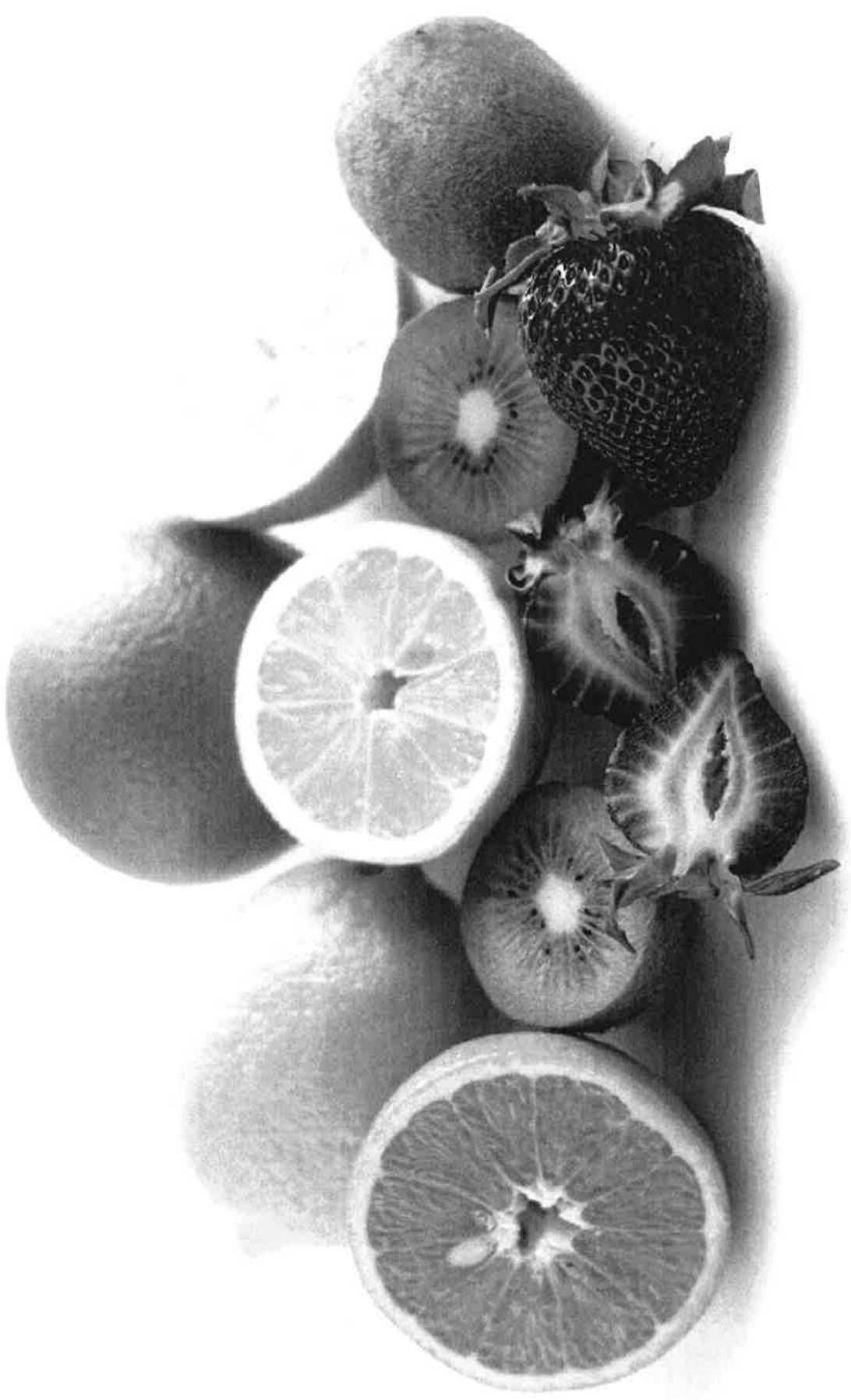


Counseling Philosophy

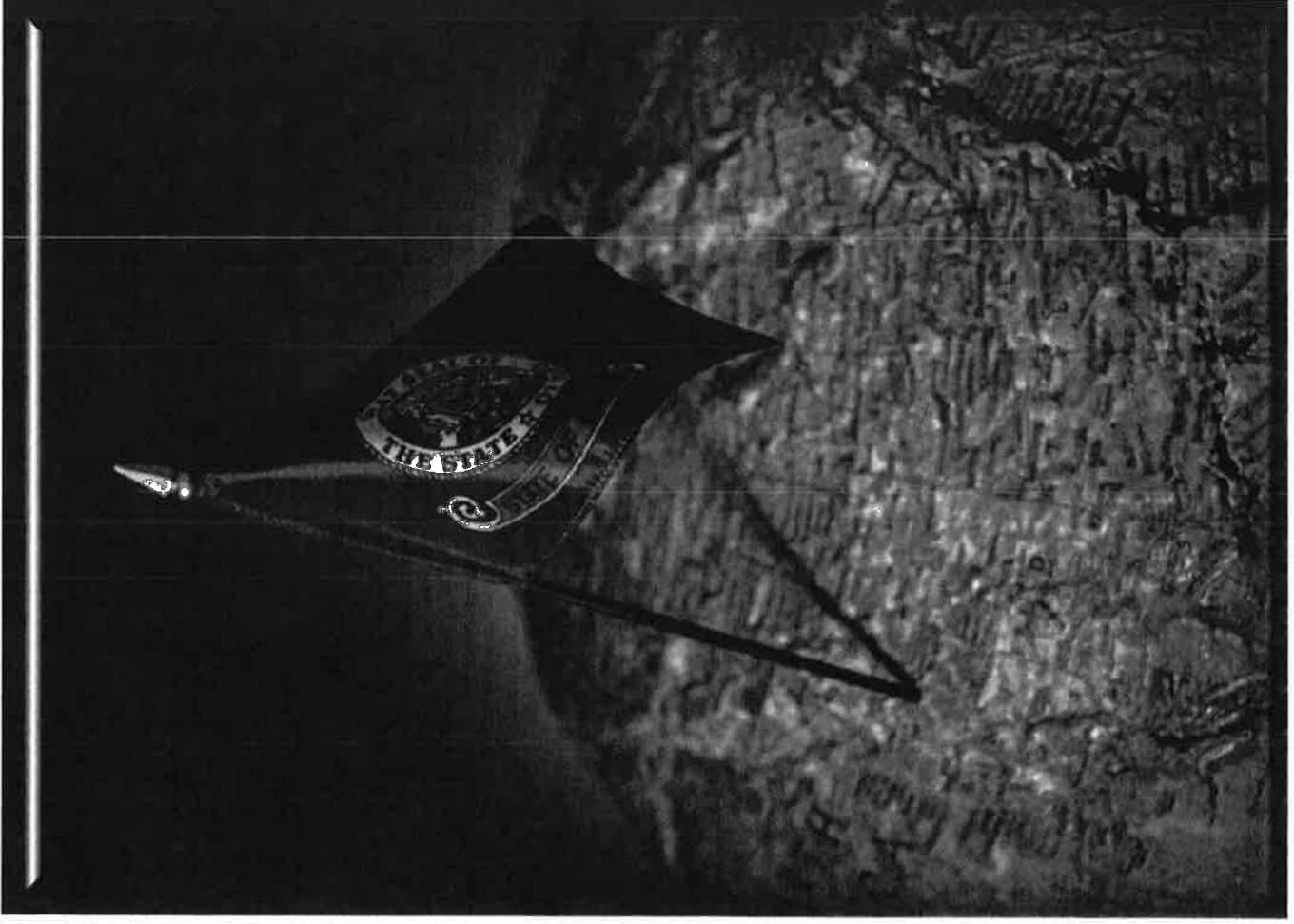
Comparable Training



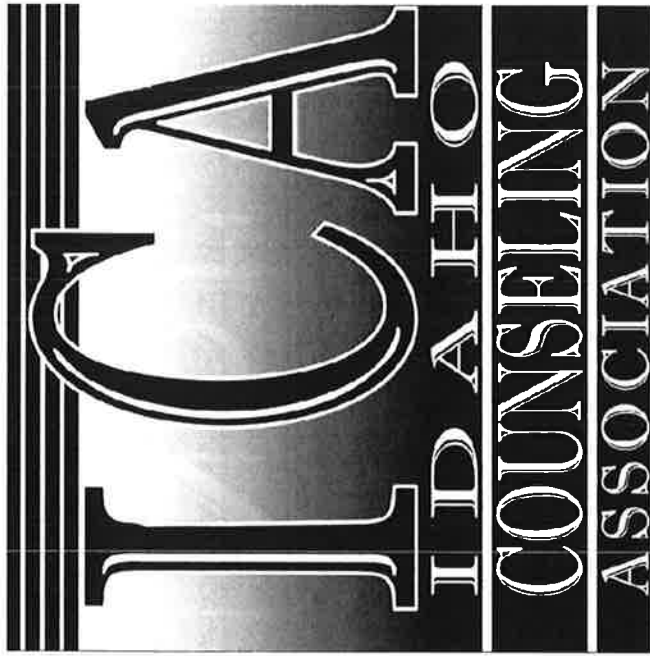
Credits & Clinical Hours



Ranked 51st in mental health



ILC
AND A HIO
COUNSELLING
ASSOCIATION



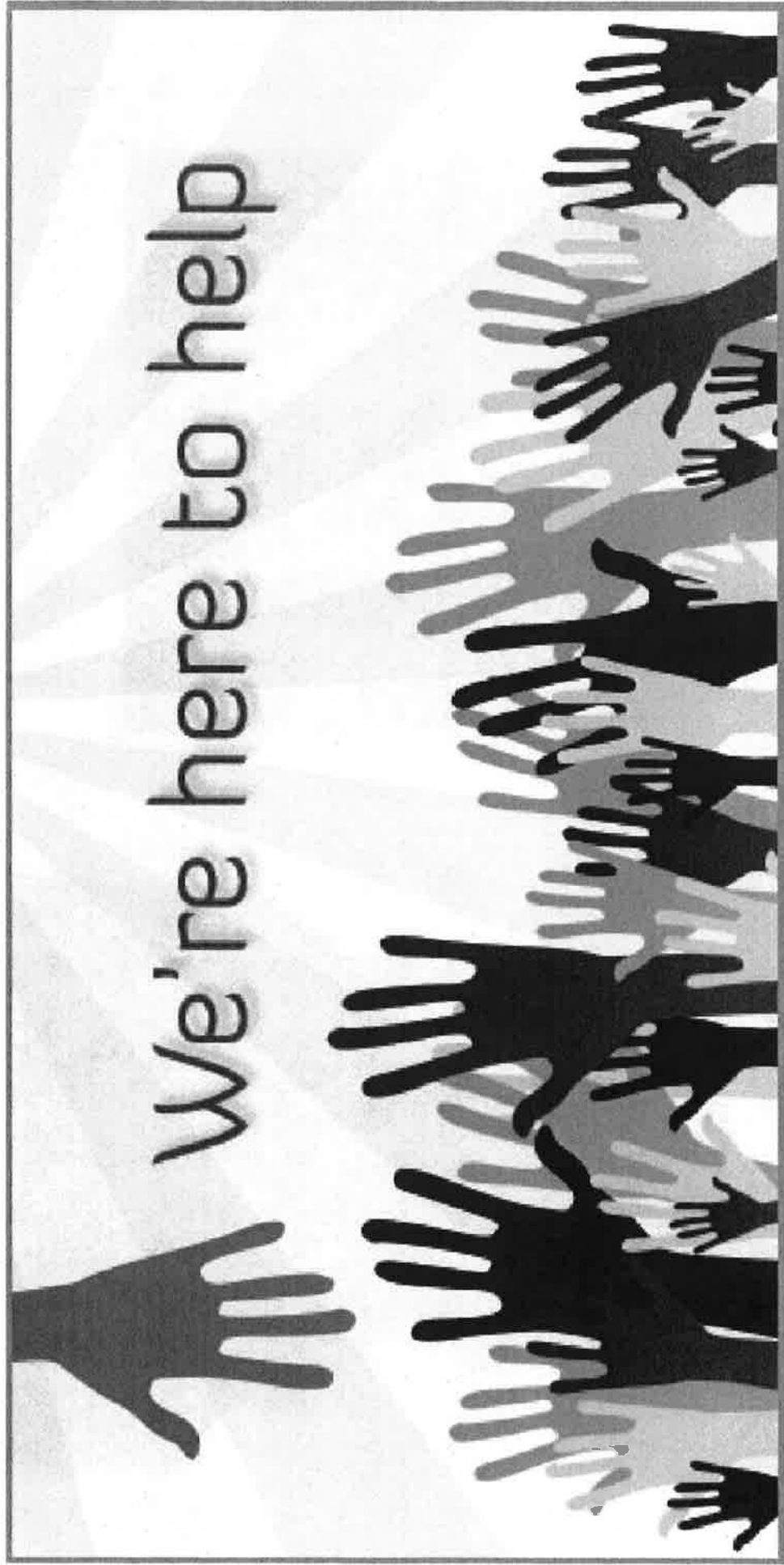
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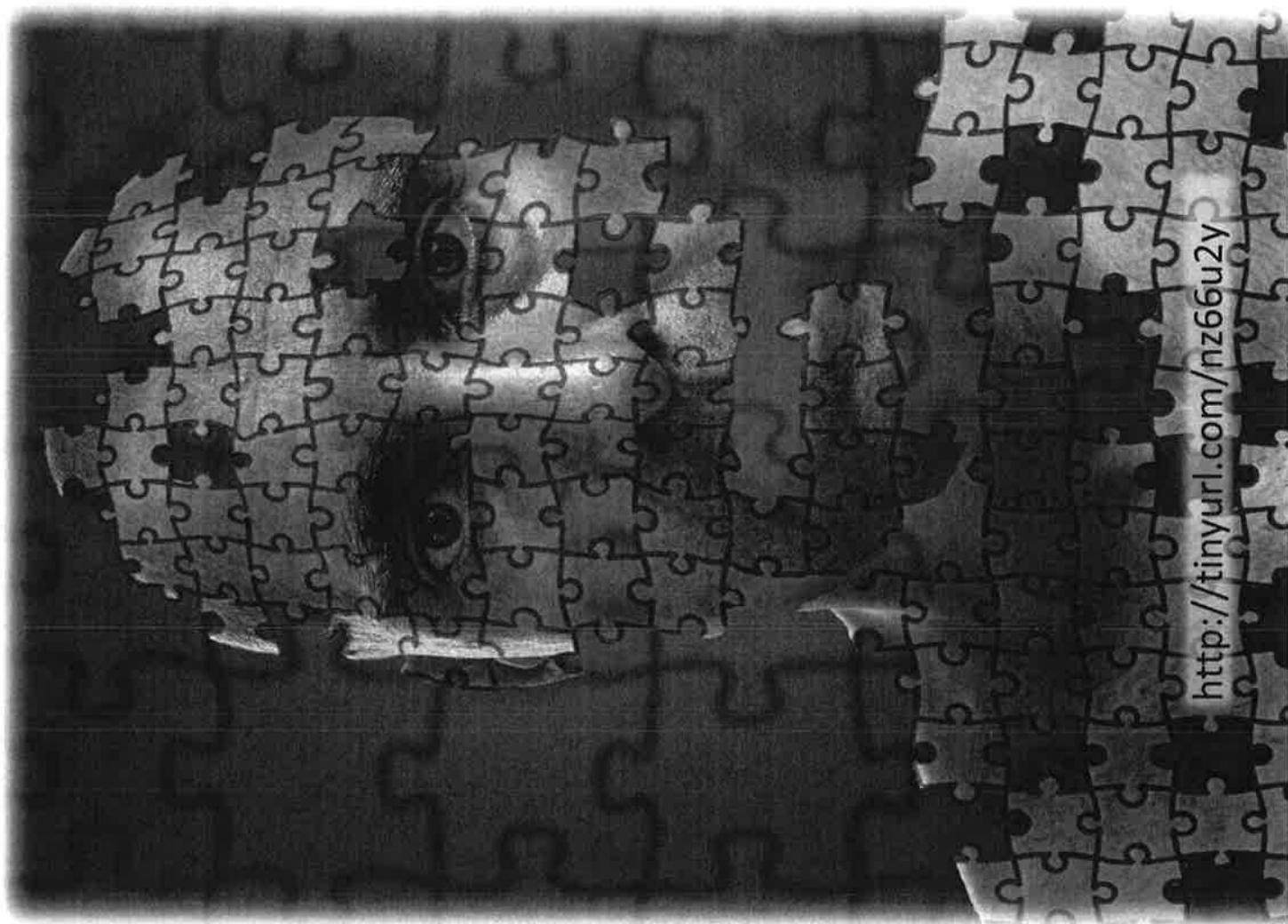
<http://gov.idaho.gov/about/seal.html>

ETHICS
GOTS

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<http://tinyurl.com/p4wcs5c>



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Medicare

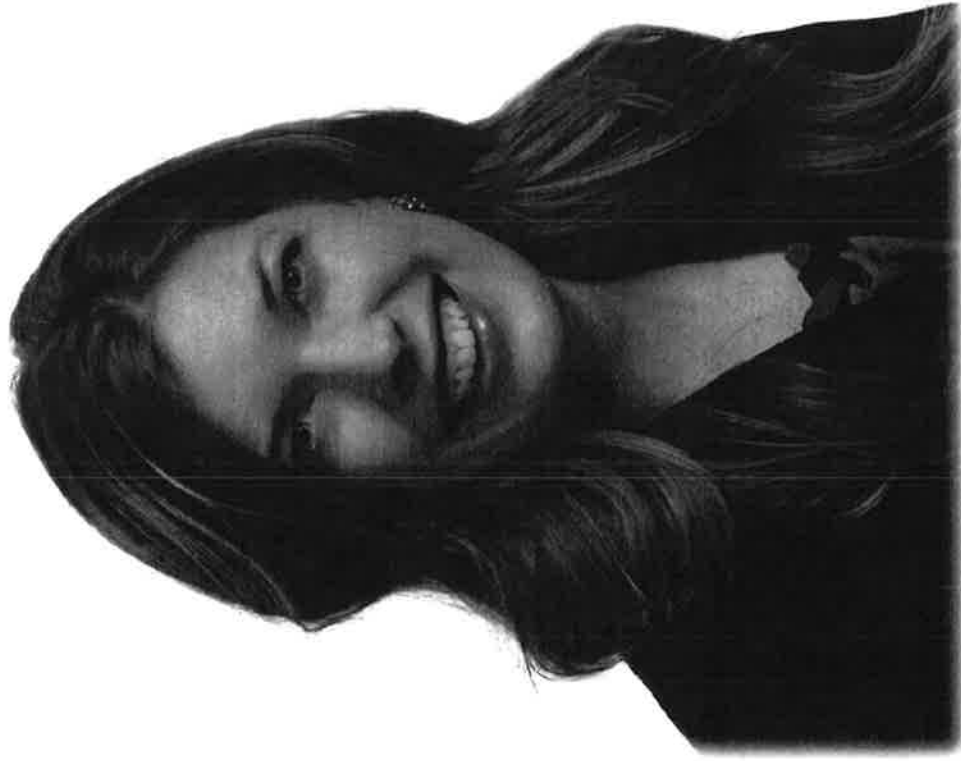
Future



<http://www.malinikaushik.com/idaho/>

We're here to help





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Idaho Counseling Association

Senate Health & Welfare Committee Presentation

March 19, 2015 Speaker notes

1. Introduce speakers: Susan Perkins, Dennis Baughman
2. What is counseling: According to the American Counseling Association, counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals.
3. What do counselors do: Counselors assess, diagnose, and treat mental health problems for individuals, couples, and families. They do career counseling, group counseling, education, school counseling,
4. Where do counselors work: Counselors work in schools and universities, government, businesses and industries, health care, residential treatment facilities, community clinics, and private practice.
5. Counseling philosophy centers on personal growth and helping people reach their goals.
6. Comparable training for counselors, marriage and family therapists, and licensed social workers is addressed on a separate handout.
7. Idaho is consistently ranked in the low 10% of states on a variety of mental health topics.
8. Who is the Idaho Counseling Association? The Idaho Counseling Association is an organization of counseling and human development professionals who work in education, health care, residential treatment, private practice, community agency, governments and business/industry settings.
 - a. Our mission is to enhance human development throughout the life span and to promote the counseling and human development profession.
9. ICA has five divisions:
 - a. Idaho Association for Counselor Education and Supervision
 - b. Idaho Association of Marriage & Family Counselors
 - c. Idaho Career Development Association
 - d. Idaho Mental Health Counselors Association
 - e. Idaho School Counselor Association
10. ICA wants to be a resource for legislators.
11. What is happening currently in Idaho legislature related to mental health?
12. Code of Ethics: Currently, licensed counselors who are members of their national association (the American Counseling Association) are bound to two ethical codes because the professional organization has a new Code of Ethics and the old ACA Code of Ethics is written into licensure law. The IBOL is proposing a law change that would update the law to the new Code of Ethics. ICA supports this.
13. Telehealth in Idaho. Telehealth services show potential in helping close the gap between need for mental health services and available services. Please remember counseling in these

conversations and think through issues that may be unique to helping professionals. Also, the gap will not be closed unless the services are covered by third party payers, which they are not currently required to do.

14. Fragmented care in Idaho. This reduces incentive for organizations to work together to provide the best possible care for clients.
15. Medicare. Although Psychologists and Social Workers can currently be reimbursed for providing mental health services through Medicare, Counselors and Marriage and Family Therapists cannot. A national bill has been on the floor in previous years (e.g., Senate—S. 562, the Wyden/Barrasso “Seniors Mental Health Access Improvement Act” in 2013; related bills in 2014) please contact legislators and ask them to support this or similar bills.
16. In the future, ICA would like to request that legislators look to counselors to help fill the mental health needs in Idaho.
17. We are here to help—we are trained to find solutions and help people and systems reach their goals!
18. Contact us any time.

AGENDA
SENATE HEALTH & WELFARE COMMITTEE
2:00 P.M.
Room WW54
Thursday, March 26, 2015

PLEASE NOTE: MEETING TIME IS 2:00 - 3:00 P.M.

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
Page Graduation	Farewell to Committee Page Christopher Miller	Chairman Heider
Minutes Approval	Approval of the Minutes for February 23, 2015	Senator Nuxoll
	Approval of the Minutes for March 2, 2015	Senator Lee
	Approval of the Minutes for March 5, 2015	Senator Tippets
	Approval of the Minutes for March 12, 2015	Senator Hagedorn
	Approval of the Minutes for March 17, 2015	Senator Hagedorn
<u>S 1177</u>	RELATING TO NATUROPATHIC PHYSICIANS - Repeals existing law relating to licensure of Naturopathic physicians	Senator Schmidt

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippets
Sen Lee
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Thursday, March 26, 2015

TIME: 2:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: Senator Lodge

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the Senate Health and Welfare Committee (Committee) to order at 2:04 p.m.

PAGE GRADUATION: **Chairman Heider** recognized Page Christopher Miller and asked him to tell the Committee about his experience as a page and what his plans are for the future. **Mr. Miller** stated he is planning to work for the Pepsi Company and attend The College of Western Idaho for his core classes. He will then transfer to Boise State University to pursue a degree in computer science. He hopes to stay in Idaho working in the technology industry.

Vice Chairman Martin expressed his thanks to Mr. Miller for all his help to the Committee.

Chairman Heider presented Chris with a letter of recommendation and appreciation along with a gift from the Committee.

MINUTES APPROVAL: **Senator Nuxoll** moved to approve the Minutes of February 23, 2015. **Vice Chairman Martin** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Lee** moved to approve the Minutes of March 2, 2015. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Tippetts** moved to approve the Minutes of March 5, 2015. **Senator Lee** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Hagedorn** moved to approve the Minutes for March 12, 2015 and March 17, 2015. **Senator Nuxoll** seconded the motion. The motion carried by **voice vote**.

S 1177 **Senator Schmidt** explained that **S 1177** is part of an amendment to **H 181**. **S 1177** needs to be on the calendar should the other bill not pass.

Vice Chairman Martin asked for clarification that this bill would be a backup plan to **H 181** as amended. **Senator Schmidt** replied yes, but Idaho Code § 54-51 needs to be repealed. **Vice Chairman Martin** asked if **H 181** passes would there be no need to proceed with this bill. **Senator Schmidt** answered yes.

Vice Chairman Martin questioned if **H 181** passes, then what would be the status of **S 1177**. **Senator Schmidt** replied the goal is to have this bill available for consideration. He is comfortable with it on the calendar in either body.

Chairman Heider commented that both bills take away Idaho Code § 54-51.

Senator Tippetts stated he has a conflict of interest pursuant to Senate Rule 39 (H), but he intended to vote.

Senator Hagedorn commented that sending the bill to the calendar would place it so that a unanimous consent request could be made to hold it until a date certain. It could Sine Die without a hearing if need be.

MOTION: **Senator Hagedorn** moved to send **S 1177** to the floor with a **do pass** recommendation. **Senator Lee** seconded the motion.

DISCUSSION: **Senator Nuxoll** mentioned that many naturopaths have worked on **H 181** and a were satisfied with that bill and feel that about **S 1177** is more of a threat. She cannot support this bill.

Senator Tippetts expressed concern in trying to make amendments to important issues without a hearing. He wants to continue working on this issue to improve it. He would like to have more time to have a Committee hearing. He will not be supporting the motion.

Senator Hagedorn stated there are some people practicing naturopathic services that know they are practicing outside of the scope of § 54-51. These people fall outside of the decision of the Idaho Supreme Court in 1959 which defined what naturopathic services were. Those people cannot support **H 181** as it would put them at risk of being investigated. He emphasized it concerns him as Idaho might have a public health problem with people practicing outside of their scope. Only by removing § 54-51 can this issue be eliminated. This allows all of them to practice.

Senator Nuxoll questioned the public health concerns, as that was not raised during testimony. She does not feel it is a public health issue. All she has heard is how people have been helped and cured.

Senator Tippetts asked for a clarification on the people who are operating outside the limits of Chapter 51, Title 54, and how repealing this resolves the issue.

Senator Hagedorn replied this will not fix the problem. The board was supposed to create the rules to establish the scope of limitation of practice for each group and their education criteria. But it never happened and doesn't exist. There is no one to investigate the practices, investigate the complaints, or address resolutions. The Board of Occupational Licensing has had over 12,000 complaints and has been trying to figure out what needs to be done. There is nothing active about this chapter and if the Committee repeals it, it will force those who are practicing to come together and create rules.

Senator Jordan stated she supports this motion. There has been a tremendous number of negotiations going on to make **H 181** work. The board is non functional and needs to go away.

Senator Lee said if the emails, phone calls, and testimony are indications of how difficult it has been to bring these two groups together, she does not see a way forward with resolution by leaving in a dysfunctional part of statute. These groups are different from each other and differences are recognized. With those differences there will be different paths for primary health care for Idahoans.

Senator Schmidt commented he has been on the website for the American Association of Naturopaths Medical Examiner, which is the test entity for naturopaths. The site listed the states that license naturopaths. Idaho is not one of them. Next to the list is a map. On this map it shows states that license naturopaths and Idaho is highlighted. It is a clear picture of how unclear the issue is. The Legislature needs to provide clarity and removing § 54-51 helps do this.

Chairman Heider thanked Kris Ellis for her hard work and her time spent on **H 181** and **S 1177**.

**ROLL CALL
VOTE:**

Chairman Heider called for a roll call vote. **Senators Hagedorn, Lee, Schmidt, Lacey, and Chairman Heider** voted aye. **Vice Chairman Martin, Senator Nuxoll, and Senator Tippetts** voted nay. Senator Lodge was absent and excused. The motion carried.

ADJOURNED:

There being no further business, **Chairman Heider** adjourned the meeting at 2:30 p.m.

Senator Heider
Chairman

Erin Denker
Committee Secretary

Barbara Lewis
Assistant Secretary

AMENDED AGENDA #1
SENATE HEALTH & WELFARE COMMITTEE
2:00 P.M.
Room WW54
Monday, March 30, 2015

SUBJECT	DESCRIPTION	PRESENTER
	Welcome and Introductions	Chairman Heider
	Minutes Approval:	
	Approval of the Minutes for January 27, 2015	Senator Nuxoll
	Approval of the Minutes for February 18, 2015	Senator Schmidt
	Approval of the Minutes for February 24, 2015	Senator Schmidt
	Approval of the Minutes for March 10, 2015	Senator Schmidt
<u>HCR 19</u>	RELATING TO EMERGENCY MEDICAL SERVICES - Prepare Legislation on Emergency Medical Services in Idaho	Rep Luke Malek
<u>H 298</u>	RELATING TO PAYMENT OF MEDICAID PROVIDERS - Provide that certain services provided to adolescents shall be reimbursed at percentage of current Medicare rate	Jeff Morrell, CEO Intermountain Hospital
<u>HCR 24</u>	RELATED TO FAMILY CAREGIVERS - Creating a task force to explore innovative means to support uncompensated family caregivers in Idaho	Lee Flinn, AARP Idaho

If you have written testimony, please provide a copy of it along with the name of the person or organization responsible to the committee secretary to ensure accuracy of records.

COMMITTEE MEMBERS

Chairman Heider
Vice Chairman Martin
Sen Lodge
Sen Nuxoll
Sen Hagedorn

Sen Tippetts
Sen Lee
Sen Schmidt
Sen Jordan

COMMITTEE SECRETARY

Erin Denker
Room: WW35
Phone: 332-1319
email: shel@senate.idaho.gov

MINUTES
SENATE HEALTH & WELFARE COMMITTEE

DATE: Monday, March 30, 2015

TIME: 2:00 P.M.

PLACE: Room WW54

MEMBERS PRESENT: Chairman Heider, Vice Chairman Martin, Senators Lodge, Nuxoll, Hagedorn, Tippetts, Lee, Schmidt and Jordan

ABSENT/ EXCUSED: None

NOTE: The sign-in sheet, testimonies and other related materials will be retained with the minutes in the committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting of the Senate Health and Welfare Committee (Committee) to order at 3:02 p.m.

APPROVAL OF MINUTES: **Senator Nuxoll** moved to approve the Minutes of January 27, 2015. **Senator Martin** seconded the motion. The motion carried by **voice vote**.

APPROVAL OF MINUTES: **Senator Schmidt** moved to approve the Minutes of February 18, 2015. **Senator Jordan** seconded the motion. The motion carried by **voice vote**.

HCR 19 **Darby Weston**, Ada County Paramedics, presented **HCR 19** which is a resolution to direct the Department of Health and Welfare's Bureau of Emergency Medical Services and Preparedness (EMS) to convene a working group to review the Office of Performance Evaluations' (OPE) recommendations for improvement of the emergency medical services system and draft legislation for consideration in the 2016 Legislature.

Mr. Weston explained that the outdated statutes no longer adequately serve Idaho's needs. In 2010, at the direction of the Joint Legislative Oversight Committee, the OPE issued the "Governance of EMS Agencies in Idaho" report, which identified seven characteristics of a well-functioning EMS system and gaps that exist between those characteristics and the current state of EMS in Idaho.

The 2013 follow-up report from OPE noted the collaborative efforts taking place in several Idaho counties to develop EMS systems; however, there has been no legislation offered to: (1) assure statewide EMS coverage, (2) create the structure for local governance and medical directorates, and (3) increase the role of the Bureau of Emergency Medical Services and Preparedness. He said this legislation proposes to address these issues.

Senator Tippetts asked if the EMS could convene a task force for this purpose without this resolution and, if so, what is the actual intent of the resolution.

Mr. Weston replied that the resolution allows the EMS access to the Office of Legislative Services to receive further resources to move forward and also provides a timeline to craft a solution that will be brought back to the Legislature in 2016.

TESTIMONY: **Shawn Rayne**, Deputy Director of Operations, Ada County Paramedics Association, testified in support of **HCR 19**. He said this resolution will allow the Paramedics Association to serve all people with a higher standard, and the improved system will also save the EMS resources.

Chairman Heider asked who would be included in the working group and how many people would be involved. **Mr. Rayne** said the task force would include stakeholder engagement from all areas of the State, including the most rural. He was not yet sure how many individuals would comprise the task force.

Senator Schmidt asked what would happen if there is no legislative action. **Mr. Rayne** replied that without legislative guidelines there would be nothing to hold the system together.

Senator Martin asked if there would be a fiscal impact down the road. **Mr. Rayne** said significant savings would be realized by working with the system.

MOTION:

Senator Martin moved to send **HCR 19** to the floor with a **do pass** recommendation. **Senator Nuxoll** seconded the motion.

Senators Hagedorn and **Lodge** expressed doubts about the need for the resolution. **Representative Malek** took the podium to clarify their questions. He said there was concern about whether current Idaho Code supports the many differences specific to every area. He explained the purpose of the task force is to make sure best practices are behind the system and there is good law at the localities.

**ROLL CALL
VOTE:**

Chairman Heider called for a roll call vote. **Senators Jordan, Schmidt, Lee, Tippetts, Nuxoll, Vice Chairman Martin,** and **Chairman Heider** voted aye. **Senators Lodge** and **Hagedorn** voted nay. The motion carried. Senator Martin will carry the bill on the floor.

H 298

Jeff Morrell, Chief Executive Officer, Intermountain Hospital, presented **H 298**, the purpose of which is to create a reimbursement methodology for services provided to an adolescent by a private, freestanding mental health facility. He said the current methodology is based on antiquated cost reporting that is currently followed by only four other states. He said the cost reporting does not reflect how freestanding psychiatric facilities that operate at highly efficient levels maintain a program based on limited funding resources.

Mr. Morrell explained that Intermountain Hospital currently has 30 adolescent beds which serves a large part of southern Idaho. He said this legislation would enable the hospital to open 15 additional beds for adolescent mental health treatment on an inpatient basis. **Mr. Morrell** said there were 495 deflections, or the inability to treat appropriately referred adolescent patients, in 2014 and there have been 120 deflections to date in 2015.

Mr. Morrell said St. Luke's Hospital is unable to provide adequate mental health care because its focus is mostly on medical and surgical patients. He noted that St. Luke's physicians agree that mental health patients are more appropriately treated in a mental health facility where they are in a safer environment. He said approval of this legislation will open beds not only for Medicaid patients but will provide services for all patients including those commercially insured, indigent or charity.

Mr. Morrell explained these mental health adolescents are largely suicidal patients who require specialized treatment in a safely monitored environment.

TESTIMONY:

Toni Lawson, Vice President of Governmental Relations, Idaho Hospital Association, testified in support of **H 298**. She said the resources available to these adolescents are extremely limited and emphasized the importance of increasing the number of beds to serve this very vulnerable segment of Idaho's population.

Lisa Hettinger, Division Administrator for the Medicaid Division of the Department of Health and Welfare (Department), said the legislation is important to ensure that a viable payment methodology is established. In answer to earlier questions from the Committee, she clarified the various reimbursement methodologies for different hospital facilities. **Senator Tippetts** asked if the Department supports this legislation. **Ms. Hettinger** said the Department is neutral; however, it does not oppose the legislation and sees the need.

MOTION: **Senator Martin** moved to send **H 298** to the floor with a **do pass** recommendation. **Senator Hagedorn** seconded the motion. The motion carried by **voice vote**. Senator Schmidt will carry the bill on the floor.

H 24 **Lee Flynn**, AARP Idaho and the Idaho Caregiver Alliance, presented **HCR 24**, which is a replacement for **SCR 123** passed by this Committee earlier in March. **Ms. Flinn** explained that the House of Representatives had requested two changes to the legislation: (1) References in the fiscal note were removed as to legislative participation. As such, no fiscal impact is reflected. The Idaho Caregiver Alliance will invite Legislators to participate and is prepared to reimburse those Legislators for their expense; and (2) Relating to the State Health Insurance Assistance Program (SHIP), the wording was changed to clarify that the task force will provide information to SHIP leaders, and the task force is not directing SHIP in any way.

MOTION: **Senator Tippetts** moved to send **H 24** to the floor with a **do pass** recommendation. **Senator Martin** seconded the motion. The motion carried by **voice vote**. Senator Lee will carry the bill on the floor.

ADJOURNED: There being no further business, **Chairman Heider** adjourned the meeting at 3:00 p.m.

Senator Heider
Chair

Erin Denker
Secretary

Jeanne' Clayton
Assistant Secretary